Beechdale Care Limited

Beechdale Manor Care Home

Inspection report

40 Beechdale Road
Nottingham
Nottinghamshire
NG8 3AJ

Tel: 01158496400
Website: www.beechdalecare.co.uk

Date of inspection visit:
20 October 2021

Date of publication:
18 March 2022

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Beechdale Manor is a residential care home providing personal and nursing care for up to 65 people. The service accommodates people in one adapted building which is set out across three floors. The ground floor accommodates people who have a higher level of mobility and less complex needs. The first floor specialises in providing care to people living with dementia. The second floor provides care and support for people with more complex and palliative care requirements. At the time of our inspection there were 61 people using the service.

People's experience of using this service and what we found.
Risks associated with people's care and support and the environment were not managed safely. This placed people at risk of harm. Opportunities to learn from incidents had been missed. Medicines were not always stored or managed safely. There were not always enough staff to meet people's needs and ensure their safety.

Safe recruitment practices were followed, however, staff lacked effective support to carry out their roles.

The home was not clean or hygienic. Infection prevention and control practises were ineffective and the risk of cross contamination was high.

People were at risk of dehydration and malnutrition due to poor monitoring and failure to follow nationally recognised guidance.

Overall, people were supported with their health needs and had access to healthcare services, although care plans did not always contain personalised health information. The service was adapted to meet people's needs. People were not always supported by staff who had training to meet their needs.

Relatives often struggled to contact the home for updates on loved ones.

Beechdale Manor was not well led. The manager failed to identify major concerns about health and safety and infection control. The provider did not operate effective governance systems to ensure the quality, safety or improvement of people's care when needed. There had been a failure to identify and address issues with the health, safety and quality of care provided. Audits were not always effective, and the provider did not have sufficient oversight of the running of the home. There were limited opportunities for people and staff to get involved in driving improvements.

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

Rating at last inspection
The last rating for this service was Good (Published 1 September 2020)

Why we inspected
The inspection was prompted in part due to concerns received regarding medicines management, safe care and dignity and respect for those using the service. As a result, we undertook a focused inspection to review the key questions of Safe and well-led only.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-Led sections of this report.

You can see what action we have asked the provider to take at the end of this report. The provider did send an action plan to give assurance that serious risk had been mitigated. The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Beechdale Manor on our website at www.cqc.org.uk.

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 risk management, the environment, safeguarding, staffing, how people are treated and leadership and governance at this inspection.

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

We will work alongside the provider and 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.

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?

Inadequate

The service was not Safe.

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The Service was not Well-Led.

Details are in out Well-Led findings below.

Beechdale Manor Care Home

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 a Specialist Nurse Advisor

Beechdale Manor 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. This means that the provider is 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 used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and

improvements they plan to make. This information helps support our inspections. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, we contacted Healthwatch for feedback on the service, Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and three relatives about their experience of the care provided. We spoke with nine members of staff including the manager, nurses, the service administrator, senior care workers, care workers, maintenance staff and the cook.

We reviewed a range of records. This included eleven people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We contacted the Nottinghamshire Fire and Rescue Service and Environmental Health to request further checks be carried out owing to concerns identified at inspection.

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant that people were not kept safe from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not protected from avoidable harm. People were at high risk of skin damage and deterioration. The manager told us there were no issues with people's skin. However, we found photographic evidence there were eight people with pressure sores and skin tears. Photo's had been taken recently but not allocated to the files of people who had sustained the injuries. This meant people were at risk of not receiving care and treatment and experiencing further breakdowns of their skin and a risk of infection.
- Settings on pressure relief mattresses were not safely managed and monitored. Repositioning charts were not accurate and did not evidence compliance with advice given by health care professionals. This also increased the risk of people developing pressure sores and placed those who had pressures sores at greater risk of skin deterioration.
- People were not protected from abuse and improper treatment from staff. We observed an agency staff member mocking one person who had dementia. The other staff present did not challenge this practise. We reported this to the provider who dealt with this after the inspection.
- We also observed people's needs were disregarded as staff wilfully ignored people's request for help and on one occasion, we intervened to meet the person's needs. Furthermore, we saw one person was subjected to degrading treatment as they were sat at the dining table with faeces under their fingernails. Staff did not notice or offer assistance with regard to ensuring the person was clean before supporting the person to the dining room.
- One person had been provided with bedrails. We were told this was because of a risk of falls, however, there was no evidence that the person had fallen from the bed. The rails had not been issued after an assessment from a professional which posed a risk of avoidable harm. Family had requested bedrails but there was no evidence that the use of bedrails was discussed with the family.

The failure to protect people from abuse and improper treatment was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks were not assessed, monitored or managed effectively. People were at risk of skin damage when receiving personal care. We observed some staff were wearing rings with stones in and watches. This posed a risk of cross contamination and also harming a person whilst delivering personal care.
- One person had been diagnosed with a chronic long-term health condition. There was no care plan, risk assessment or any information for staff to follow to effectively manage symptoms. This posed a risk that staff were unable to effectively care and support the person should symptoms present.

● There was an increased risk of fire. We found that paper had been pushed through the vents of several radiator covers. This had accumulated over time which increased the risk of fire. These were cleaned out after the inspection and a maintenance plan put in place with advice from the fire service.
● People were not adequately protected from the risk of Legionella. There were not sufficient control measures in place to reduce the risk of legionella growth in the water supply. These issues increased the risk of legionella developing which could have a negative impact on people's health.
● Water temperature checks had not taken place. This put people at risk of scalding.

Using medicines safely
● Medicines were not managed safely. One person who had a long-term chronic health condition had missed essential medication for five consecutive days. This had not been identified prior to the inspection (and/or) there was no evidence of action taken to seek medical advice and avoid adverse side effects. This posed a risk to symptoms increasing and causing distress.
● Staff did not have written guidance on the safe management of people's wounds. One person had a dressing applied to a skin tear which had not been prescribed for them. This meant that the skin condition could deteriorate, or they may have an allergic reaction to the dressing.
●One person had chosen to self-medicate, this included a controlled drug which was not managed or monitored by staff to ensure that the medicine had been taken safely. There was no information recorded for two weeks and no management oversight. The manager told us that this was recorded on the medication administration record (MAR). It was not.

Preventing and controlling infection
● The service did not have effective systems in place to prevent infection or cross contamination. Clinical waste bins were overflowing in bathrooms and there was malodour throughout the service.
● Clinical waste was not managed safely. Industrial containers outside were overflowing and there was a quantity of clinical waste bags on the floor. This was situated outside the kitchen. The refuse area gate was not locked. This was reported through to environmental health.
● Equipment used for moving and handling people was heavily soiled. There was significant staining on soft furnishings. Personal protective equipment was not consistently worn.
● People's rooms were not effectively cleaned. One person had been absent from the home for seven days. We found that there was urine in their toilet and the room had not been cleaned.
● Medicine rounds were not managed safely. The tabard worn by staff giving medicines was heavily soiled and stained. The medication trolley was also soiled and there was no hand sanitiser for staff use. We observed gloves were not changed between giving people their medicine. This posed a risk of cross contamination and infection.
● One relative told us that they had not been asked for their lateral flow test result on entering the premises, this meant that the provider was not always ensuring people did not have COVID-19 as far as was possible. We could not see that people were socially distanced in communal areas.

● We were not assured that the provider was preventing visitors from catching and spreading infections.
● We were not assured that the provider was meeting shielding and social distancing rules.
● We were not assured that the provider was admitting people safely to the service.
● We were not assured that the provider was using PPE effectively and safely.
● We were not assured that the provider was accessing testing for people using the service and staff.

● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were not assured that the provider's infection prevention and control policy was up to date.

The failure to provide consistently safe care and treatment in relation to risk, medication and infection control was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment

● There were not always enough staff deployed to ensure people's safety and wellbeing.

● Staff did not have the time to engage with people in a meaningful way. We saw people sat for long periods with no activities or conversation. The lack of interaction within support posed a risk of people becoming unwell. For example, people were not supported to eat and drink, this posed a risk to dehydration and malnutrition.

● The dependency assessment to calculate staffing was ineffective. It did not reflect the needs of people using the service or pose as an effective tool to influence the rota. This posed a risk to people not receiving care in a timely manner.

The failure to deploy enough staff, was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment practises had been followed and staff had received an induction and training. However, regular refresher training had not always taken place.

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

- There was insufficient leadership at the service. There was a manager who had been in post for four weeks and applied to register with the Care Quality Commission. At the time of our inspection the application had not been approved. The provider had failed to identify failings within the service.
- Systems and processes were either not in place or not robust enough to maintain effective managerial oversight of the service. The provider told us that they would normally have regular oversight of the service. This had not happened because of COVID-19 and other factors.
- There had been a provider failure to identify the serious concerns found during our inspection therefore we were not assured that there was an understanding of quality performance or risk at the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Continuous learning and improving care.

- The culture of the home did not consistently promote good care outcomes for people. We shared feedback about our observations of people waiting for care.
- Staff told us that they did not feel supported. Supervision notes supported this statement, identical notes were recorded for each staff member and did not engage staff. One staff member told us "We don't have supervision and we don't see management around.''
- We observed people who required assistance and support did not receive either. Two people were struggling to eat lunch and were unable to use the cutlery provided. Staff took plates away without offering support or checking if they had finished their meal. Staff had not received appropriate support and training around ensuring people had enough to eat and drink.
- Management audits were not effective and lacked completion. This meant that there was a lack of management oversight throughout the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Opportunities for people and staff to get involved in the running of the home were limited.
- There was no evidence that staff were engaged with in a meaningful way. There were no opportunities given to staff to suggest changes or improvement to the service.
- We didn't observe any meaningful engagement with people using the service or their relatives. There were no tools used to obtain feedback such as meetings or questionnaires.

The failure to ensure effective governance and leadership was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- We did not find evidence that the management team had acted on the duty of candour.
- Relatives struggled to contact the service and discuss concerns with the manager. One relative told us "We have spent many hours to try to get an update on [name].'' Relatives were not assured that they would be contacted if things went wrong.

Working in partnership with others

- People were referred on to specialist healthcare professionals when their needs changed, and they required further assessment.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to provide safe care and treatment in relation to medicines, infection control and welfare of people.

The enforcement action we took:

Served a letter of intent after the inspection and then notice of proposal to impose conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The failure to keep people safe from avoidable harm.

The enforcement action we took:

Serve a letter of intent followed by a notice of proposal to impose conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Lack of management oversight in all areas of the service.

The enforcement action we took:

Serve a letter of intent followed by and notice of proposal to impose conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to deploy staff effectively and manage and monitor staffing levels.

The enforcement action we took:

Served a letter of intent followed by a notice of proposal to impose conditions.