Mr Gurpal Singh Gill

Beacon House Nursing Home

Inspection report

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Date of inspection visit:
25 July 2018
27 July 2018

Date of publication:
10 September 2019

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

We undertook an unannounced inspection of Beacon House on 25 and 27 July 2018. The inspection was prompted by the inspection of a second nursing home owned by the provider which was inspected in April 2018. The nursing home was rated as Inadequate and placed in special measures.

Beacon House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Beacon House can provide accommodation and nursing care for up to 22 people with general nursing needs and end of life care. At the time of the inspection 18 people were receiving care at Beacon House.

We last inspected Beacon House on 17 October 2017 and it was given an overall rating of Good with safe being rated as requires improvement without any breaches of Regulation.

At this inspection of 25 and 27 July 2018, we have rated the service inadequate.

At the time of the inspection a manager registered with the CQC had not been in post since November 2015. The service is owned by an individual who was registered to provide one other care home. The provider told us they were considering asking the care coordinator to apply to be registered as the manager for Beacon House. 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 were at risk because they did not receive their medicines in a safe way.

Processes were not in place to ensure the risk of infection was reduced for people using the service. People were placed at further risk because cleaning products and other chemicals were not stored in a safe way.

Risk management plans were not in place to provide care workers with the information to enable them to mitigate these risks when providing care.

Incidents and accidents were not always recorded and investigated so appropriate actions could be taken to reduce the risk of reoccurrence.

The provider had an induction process but records were not completed to demonstrate new staff had undertaken this and had been assessed as competent.

Window restrictors were in place but not used correctly to reduce risk of falls. Some fire doors were not able to close fully which prevented them working as they should.

Personal Emergency Evacuation Plans did not provide sufficient and up to date information to enable people to be evacuated safely from the home in care of an emergency.

People told us they felt safe when they received care at the home but we saw processes for the investigation and review of safeguarding concerns had not been followed.

The recruitment process was not robust as appropriate references were not always in place before assessing applicants' suitability for the role.

The provider did not deploy adequate number of staff to meet people's support needs.

People did not have maximum choice and control of their lives and staff practices were restrictive.

The service was not always caring as staff did not have enough time to give people they support they needed.

People's care plans did not include the person's wishes about how they wanted their care provided as they were focused on care tasks. Records did not provide up to date information relating to people's care. There were no structured activities planned that met people's areas of interest and were meaningful.

The provider had audits in place but these did not identify areas where improvement was required

People knew how to raise complaints or concerns relating to the care they received.

People told us they were happy with the food choice and how it was provided.

We found eight breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to person-centred care (Regulation 9), dignity and respect (Regulation 10), need for consent (Regulation 11), safe care and treatment of people using the service (Regulation 12), safeguarding service users (regulation 13), good governance of the service (Regulation 17), staffing (Regulation 18) and fit and proper person employed (Regulation 19)

We are taking action against the provider for failing to meet regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

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?

Inadequate

The service was not safe.

The provider's medicines policy and procedure was not always followed and appropriate guidance was not provided for staff.

Risk management plans were not in place to provide care workers with the information to enable them to mitigate these risks when providing care.

Incidents and accidents were not always recorded and investigated so appropriate actions could be taken to reduce the risk of reoccurrence.

Cleaning products and other chemicals were not stored in a safe way.

Window restrictors were in place but not used correctly to reduce risk of falls.

Some fire doors were not able to close fully which prevent them working as they should.

Infection control processes were not followed in relation to soiled waste.

Personal Emergency Evacuation Plans did not provide sufficient and up to date information to enable people to be evacuated safely from the home in care of an emergency.

The provider's processes for the reporting, investigation and review of safeguarding concerns had not been followed.

The recruitment process was not robust as appropriate references were not always in place before assessing applicants' suitability for the role to ensure the provider had adequate information relating to the applicant's knowledge and suitability for the role.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider did not have arrangements to ensure people had maximum choice and control of their lives and that staff support was not restrictive.

The provider had an induction process but records did not show new staff had undertaken this and had been assessed as competent.

People had access to a GP and other healthcare professionals but where changes to a person's care had been identified the information from the visit had not been transferred to the relevant care plan so staff could follow up any action that was required.

People told us they were happy with the food choice and how it was provided.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

People were not supported to engage with their community to meet their religious and cultural needs.

The service was not always caring as staff did not have enough time to give people they support they needed.

People told us they felt staff were kind, caring and respected they dignity when providing care.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's care plans did not include the person's wishes as to how they wanted their care provided. Daily records completed by staff were task focused.

Records did not provide up to date information relating to people's care.

There were no structured activities planned that met people's areas of interest and were meaningful.

People knew how to raise a complaint or concern about their care.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had audits and other checks in place but these were not effective as they did not identify areas where improvement was required so the provider could address these. Where improvements were identified the provider was ineffective in affecting change and improving the quality of the service

There was no registered manager in post at the time of the inspection as stipulated by their condition of registration and to provide effective leadership at the home.

Notwithstanding the above, people using the service and staff felt the service was well managed.

Beacon House 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.

The inspection was prompted by the inspection of a second nursing home owned by the provider which was inspected in April 2018. The nursing home was rated as Inadequate and placed in special measures.

This comprehensive inspection took place on 25 and 27 July 2018 and was unannounced.

The inspection was carried out by two inspectors, a CQC graduate analyst and a member of the CQC medicines team.

The provider had completed a Provider Information Return (PIR) in April 2017. 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. We reviewed the information sent to us in the PIR and notifications we had received from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

During the inspection, we spoke with three people who used the service, the provider, care coordinator, clinical lead and six staff including care workers and the chef. We also looked at records, including 11 people's care plans, six care worker records, medicines administration records and records relating to the management of the service. We also spoke with the local authority to obtain feedback regarding the home.

Inadequate

Is the service safe?

Our findings

The provider did not ensure the safe and proper management of medicines.

The provider had a procedure for the administration and storage of medicines but it was dated September 2010 with a section in relation to medicines to be administered when required (PRN) in 2015. Guidance was not provided for nurses in relation to the disposal of single unit dosages, such as a liquid or tablet medicine dropping on the floor, or due to a person refused the dose after it has been dispensed into a cup. Therefore, people were placed at risk because the staff responsible for managing their medicines were following procedures that were out dated and did not reflect recognised best practice guidance.

Stocks of medicines were not managed appropriately as we found multiple boxes of laxative sachets stored in a cupboard. It was noted that stock levels of the laxatives were not reviewed as part of the monthly prescription cycle to identify if additional supplies were required which resulted in over-supply. This meant there was a risk of medicines becoming out of date before being used.

We saw one person had been prescribed topical cream but the directions provided stated 'to be taken twice a day' which is guidance usually used for oral medication. This direction should state 'to be applied twice a day'. This had not been identified when the medicines had been received from the pharmacy and checked, so this could be raised with the pharmacist so the instructions could be amended appropriately.

The medicines administration record (MAR) chart for one person did not include an identification photograph to support nurses to identify the person when administering medicines. We saw photographs for other people who had their medicines administered were included with their MAR charts.

The medicine records for another person was prescribed an anti-anxiety medicine to be given when required (PRN) for agitation. We saw it had been administered every night on the MAR chart and the reason why it had been administered so regularly had not been recorded on the PRN form. If the person's need for this medicine had altered then a review should have been carried out by the GP to see if the way it was prescribed should be amended.

We found the provider had not always assessed the risks to the health and safety of service users receiving care and treatment and acted to ensure they had done all that is reasonably practicable to mitigate these risks. There was a process for the recording and investigation of incidents and accidents but this was not always followed by staff. There was a process for the recording and investigation of incidents and accidents but this was not always followed by staff. During the inspection we looked at the incident and accident records and saw two had been recorded since January 2018 in relation to people living at Beacon House and one had been recorded for a care worker. When we reviewed care plans we saw some people had experienced falls which had not been recorded as incidents and accidents. For example, we saw the records for one person indicated they had a hospital admission following a fall and the records of a GP referral for another person who had also experienced a fall. These had not been recorded as incidents and accidents and investigations had not been carried out to identity any cause or actions to reduce the risk of

reoccurrence.

The records for one person who lived with epilepsy indicated they had experienced a seizure for the first time in three years. There was no risk assessment in place in relation to epilepsy. The care plan stated the care workers should monitor and record any seizures on the specific chart but it did not identify the type of seizure the person experienced or the action which should be taken, for example if an ambulance should be called if the seizure continued for more than a specific length of time. The care plan did state that an ambulance should be called if the person experienced a seizure but there was no record of this. A record indicated the GP had been contacted the following day and had advised the staff to monitor the person.

A specific care plan had been developed for one person in relation to smoking. We also saw issues relating to smoking had been included in the care plan for environmental safety for another person. A risk assessment for smoking for both people had not been completed. The care plans stated people were aware of the smoking policy and where the smoking areas were. The provider's smoking policy, dated September 2010, stated people could smoke in an identified communal room with air ventilation, in the person's own room and in the grounds. This identified smoking area could only be used for people to smoke and as there was one communal lounge area at the home this meant this could not be used as the identified communal area. The care plans did not clearly identify where people could smoke and risk assessments were not in place to identify actions to reduce the risk to the individual, others living and working at the service and the environment; for example, to ensure the person had flame retardant material on wheelchair seating.

The stairs risk assessments for two people stated the fire doors should be kept closed but during the visit we regularly saw the fire doors were left open using a door guard system which allowed the door to close when the fire alarm sounds. In addition, the risk assessment for one person stated "[Person's name] continue to walk up/down stairs. staff to keep an eye on [person's name]" but care workers and the nurse were not always present when the person accessed the stairs. This meant practical actions were not identified to reduce the risk of falls when a person was using the stairs.

We saw the Waterlow risk assessment for skin integrity for another person stated they were incontinent but the mobilisation care plan indicated the person was fully continent and was able to use the toilet independently. This meant the information used to assess the person's risk of developing pressure ulcers was not accurate.

We saw pressure relieving mattresses were used where people were cared for in bed or were at risk of skin breakdown and a risk of developing pressure ulcers. We asked the care coordinator for a record of the checks which were carried out on the mattresses to ensure they were working and were on the correct setting to provide the person with appropriate support. The care plans for people who used this type of mattress stated staff needed to ensure that it was in good working condition and they should report faults to senior staff. The care coordinator confirmed that regular checks were not carried out and recorded to monitor the mattresses. This meant the staff could not be sure the pressure relieving mattresses were providing the required support.

There was a central stairwell providing access to all the floors. The doors leading to this stairwell were fire resistant doors. We saw some of the doors had pieces of plastic inserted into the door lock to prevent the door closing fully. As the doors were fire doors they should be able to close fully in case of a fire. This meant that people were placed at risk because fire and smoke would not be sufficiently contained in the event of a fire.

During the inspection we saw window restrictors were in place on all the windows in the home but these

had been unhooked to enable the windows to be opened fully. The windows in the bedrooms had been opened wide and people were able to access these bedrooms as the doors were left open. There were people living at the home who could mobilise independently including people who had been assessed as lacking capacity so as the window restrictors were unhooked people could be at increased risk as falling from them. The risks of falling from height had not been assessed, recorded and measures had not been identified to reduce the risks.
We raised this with the care coordinator, clinical lead and the director and they explained the windows had been opened fully as it was hot. The risks of falling from height had not been assessed, recorded and measures had not been identified to reduce the risks.

A Personal Emergency Evacuation Plan (PEEP) had been developed for each person but these did not include information which could be required to assist a person to evacuate from the building in case of an emergency. The PEEP identified the person's medical diagnosis and if any equipment such as a hoist or slide sheet was required but no information was given as to where the equipment was stored. There was a list displayed on the wall in the stairwell with people's names and their support needs in case of an evacuation but this list included the names of people who were no longer living at the home. This meant staff did not have up to date information regarding who was living at the home and how they should be evacuated in an emergency.

During the inspection we saw clinical waste was not disposed of appropriately. In each shared bathroom there was a bin with a black rubbish bag for general waste and a bin with a yellow bag for clinical waste. We saw in the bathrooms soiled continence products and used gloves were placed in the black bin bags while the yellow clinical waste bins were empty. The bins with the black bags did not have lids so the waste was easily accessible and there was a risk of cross contamination.

We found people could access cleaning products, disinfectants and other chemicals as they had not been stored securely. The doors to the sluice room and laundry area had not been secured and people could access these areas. There was disinfectant fluid stored on a shelf in the sluice room and clothes washing power accessible in the laundry. In the kitchen area located in the lounge we saw there was washing up liquid left in the sink area.

The above was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Before the end of the inspection the care coordinator confirmed staff had carried out checks of the pressure relieving mattress checks but we were not informed of the outcomes of the checks.

The provider had recruitment processes in place but these were not always followed. The recruitment procedure for the service required applicants to provide a five year work history and contact details for two references from recent employers. We saw the employment records for one recently employed staff member only had one reference on file. The records for another staff member had two references on file but it was not clear if these were provided on behalf of the previous employers or were completed by friends of the applicant and were therefore character references. Records of applicants' interviews were not completed so additional information in relation to, for example one applicant had a four year gap in their employment history were not available. This meant the provider could not fully demonstrate new staff had the required experience, skills and knowledge to provide care in a safe and appropriate manner, before they were employed.

The above was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014

We asked people if they thought there were enough care workers and nurses on duty at the home. Comments included, "If I want to go and do something else they said I can't because of a lack of staff" and "Often have staff problems, regularly I have to wait a few minutes." One person also commented that when they used their call bell staff were slower to respond at night because there were less staff on duty. We also spoke with staff to get their views on the staffing levels and some staff said there were enough staff on duty and their comments included "Yes [we have enough staff], because we have four [staff] and every morning is manageable" and "Yes, more than enough." However, three of the six staff we spoke with we spoke with though there were not enough staff. Their comments included "No, it used to be. The majority of them are leaving. Being taken for granted meant people left", and "No, now we need four staff for 18 to 20 people. Here it is double ups."

The care coordinator confirmed there were four care workers and one nurse on duty from 8am to 2pm and three care workers and the nurse from 2pm to 8pm. There was one care worker and one nurse on duty from 8pm to 8am. During the inspection we looked at the rotas for staff who worked between 25 June and 29 July 2018 and we saw these staffing levels had been allocated. At the time of the inspection 11 of the 18 people living at the home required support from two staff for mobilising and personal care. There were also two people who were independently mobile and could use the stairs but whose care plans stated they should be supervised.

We saw there were periods of time when people were in the lounge and not supervised by care workers or the nurse as they were busy in other parts of the home. On the first day of the inspection we observed people who were seated in the lounge were left without support from staff for up to 25 minutes throughout the morning. This was because the care workers and nurse on duty were busy providing support for people in other parts of the home. A system was in place to assess the level of needs and dependency each person which was completed when they moved into the home but this was not always reviewed following an incident and accident or change in the person's support needs. Care workers were also required to act as activities coordinators as part of their role as this was not seen as a separate activity. This meant the provider did not always ensure they deployed sufficient numbers of suitably qualified staff to meet the support and care needs of people using the service.

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

People we spoke with told us they felt safe from abuse or harm when they received support and care from staff. One person commented "I'm aright. They keep me safe." The provider had a process in place for the reporting and investigation of concerns. During the inspection there were no records of any safeguarding concerns that had been raised with the local authority during the past year. The local authority also confirmed they had not received or raised any safeguarding concerns during this period. We however saw examples where safeguarding referrals should have been made which the provider had not recognised. For example, from the records relating to one person we noted they had a fall which resulted in a hospital admission and treatment for a fracture. This information had not been referred to the local authority safeguarding team to be investigated to ensure the person was receiving appropriate and safe care that met their needs.

The above was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires Improvement

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

During the inspection we asked the care coordinator for a list of DoLS applications which had been made and any that were authorised. We were given a list showing 11 DoLS applications had been made between June and August 2017. The care coordinator and clinical lead were unable to provide any evidence these applications had been followed up since they were made and we did not see any records to show the applications had been authorised by the local authority. Following the inspection, the care coordinator informed us eight DoLS applications that were outstanding since 2017 had been resubmitted to a local authority. Two of these applications had been authorised. The care coordinator confirmed they were contacting the other local authority to assess the progress of the other applications that had been made. This meant that some people might have been deprived of their liberty unlawfully.

The care plans for one person stated they did not have capacity but was able to make choices. There was no mental capacity assessment to identify what impact their lack of mental capacity had in relation to making decisions about the care they received. The person had signed the consent to care form providing consent to all the care and support they received at the home but this did not relate to specific aspects of the care.

In each care plan folder, we looked at we saw a consent to care form which indicated if consent had been given for care and support to be provided for daily living activities and medical needs. The form in some care plan folders did not include the person's name and the form was not signed or dated but it indicated the person did not have capacity.

We saw a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form was completed for one person and placed in their care plan folder. The DNACPR form had been completed during a hospital admission and had not been reviewed when the person returned to the home. The DNACPR form stated the person did not have capacity to make decisions and there was no record of the person's relatives or representatives being consulted as part of the process. This meant the up to date wishes of the person and their relatives may not have been recorded accurately.

The DNACPR completed in April 2018 by the GP for another person stated they did not have capacity to make and communicate decisions about CPR. The care plans, risk assessment and PEEP for the person all stated they had capacity and were able to consent to all aspects of their care. This was not challenged so the issue could be rectified.

During the inspection we saw forms related to the person receiving a flu vaccination were in their care plan folders. The forms we saw were not dated so did not identify if the person had consented when the inoculation was last offered. Also, the forms had been signed by a member of staff but had not been signed by the person they related to. Where the person had been identified as not having the mental capacity to consent in the rest of the care plan there was no record of a best interest decision being made for the flu inoculation. This meant the was no record of the person consenting to the flu inoculation when it was annually in case they had changed their mind.

The above was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had an induction process for new staff where they completed a three to four day induction programme when they started work. This included shadowing existing staff and then they completed an induction programme including reviewing the policies of the home, information on people using the service, food and deliveries and housekeeping routines. During the inspection we looked at the induction records for three staff who had been employed since May 2018. The records for the three new staff had not been completed even though they were regularly working at the home at the time of the inspection. The care coordinator explained they gave the induction record sheet to the staff member to complete when they started working at the home and then new staff member signed off each section when completed. The form was then returned to the care coordinator when completed. There were also no records to show the new staff members had shadowed an experienced member of staff before working on their own. This meant the provider could not ensure the new staff members had the required skills and knowledge to provide safe and appropriate care.

Following the inspection, the care coordinator provided the record for mandatory training for both care workers and nurses and we reviewed the training records relating to basic life support, moving and handling infection control, health and safety and fire safety. The records did not include information about the training completed by the three new staff members whose records we reviewed. The training records also indicated that six staff had not completed their annual training for moving and handling with records showing one staff member had not yet completed the training. The records for infection control training also indicated four staff had not completed the refresher training including one staff member who last completed the training in 2015 and another who had no records indicating they had done the training.

Records indicated that staff did not have regular supervision meetings or an annual appraisal. The records for one staff member showed they had completed one supervision session since finishing their induction in March 2017. Another staff member had completed an appraisal in January 2018 but there were no other records of supervision sessions. Following the inspection, we received a spreadsheet from the provider which included dates of supervision meetings with staff. The record showed 17 staff out of 33 staff had a supervision meeting in June 2018 with four staff in July 2018. There were no records of previous supervisions meetings prior to June 2018 and no indication any appraisals were undertaken.

The above paragraphs show that the provider did not have appropriate arrangements in place to support staff to fulfil their roles."

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

People living at Beacon House could access their GP and other healthcare professionals. One person told us "The doctor comes every Tuesday and I see him and the chiropodist." When the GP visited a person a copy of the GP's computerised record of the visit was provided and placed in the person's care plan folder. If another healthcare professional visited a person they completed the multidisciplinary notes page which was in the person's care plan folder. We saw where actions had been identified during a visit the outcome had not been recorded. Also, if there had been a change to how a person's care should be provided it was not always recorded into the person's care plan. For example, one person was visited by the Percutaneous endoscopic gastrostomy (PEG) specialist nurse in April 2018 when it was identified the pump had expired and a new connector was required. The nurse had recorded that they would contact the home and another person but there was no record of this being done and the equipment replaced. A PEG is a way of introducing food, fluids and medicines directly into the stomach by passing a thin tube through the skin and into the stomach.

We asked people for their comments on the food provided at the home. They told us "The chef is lovely. She always does my food the way I like it. She is absolutely brilliant. She gives me options and I can't eat certain foods and she makes me what I can eat", "In theory they would let you eat when you ask but would ask why you hadn't eaten at mealtimes" and "It's okay. It's up to me how much I want to eat. The other day I felt like I wanted tea and biscuits and they gave it to me."

There was a chef based at the home who cooked all the meals for both Beacon House and another local home owned by the provider. During the inspection the chef told us they worked five days a week at the home and visited each person at Beacon House in the morning to ask them what they wanted for lunch. There was a four week menu cycle and the chef told us "If there are things on the menu the person does not fancy we can offer an omelette or a jacket potato. As long as they are happy."

The chef also told us "It is like a family. I like to see the whole lunch through so I can get any feedback and encourage them to eat something else." During the inspection we saw the chef checked with people in the lounge during lunch to make sure they were happy with their meal. They also identified where one person had not eaten their lunch so the chef supported the care worker to encourage the person to eat their dessert while an alternative meal was identified. This meant the person had been offered something they wanted to eat during lunch instead of them being left until the next meal.

We saw an assessment of a person's support needs had been completed before they moved into the home. The information from the needs assessment was used to develop the care plan and risk assessments.

Requires Improvement

Is the service caring?

Our findings

We saw the care plans identified the person's religious and cultural needs including their preferred language but people were not supported to access their community.

A 'residents' meeting' was held during the inspection and we saw the care coordinator and clinical lead ask people using the service if they had any preferences for outings and day trips. A number of people attending the meeting stated they wanted to visit the gurdwara or temple. The care coordinator told people they would look into this and how it could be achieved. Following the meeting we asked people if they had been supported to visit the gurdwara and two people confirmed they had not visited the gurdwara for more and a year. They told us they would like to be supported to attend regularly. We asked a care worker if the home was visited by any representatives of the faith groups reflecting the religious beliefs of people using the service. The care worker told us the provider arranged for representatives from the local gurdwara to visit the home once a year for a specific event but regular visits did not occur.

This meant people were not always supported to have involvement in their community and follow their religious beliefs.

The above was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People we spoke with told us they felt the staff were kind and caring. Their comments included "They always talk in English. There are always two care workers to wash me and they turn me so they don't hurt me" and "The day before yesterday I wanted to sit in the garden and they said yes, no problem. I can get up and go to bed when I want." People also confirmed they were happy with the care their received with one person saying "It's good. The staff are friendly. They know my routine."

Notwithstanding the feedback we received from people we saw while some individual care workers and nurses provided support for people in a kind and caring manner, the provider has not ensured that the service was caring enough by giving staff enough time to provide holistic support to people's interpersonal and support needs. This was because the provider had not ensured there was adequate leadership at the home and effective arrangements in place to provide a consistency in the quality of care. People's quality of life as not as good as it might have been as the provider had not acted in response to the lack of activities at the home which could lead to people leading fulfilling and meaningful lives.

We saw one person who used a wheelchair was being taken to the hospital for an appointment by the transport service. The ambulance crew arrived with a trolley to move the person as they had not been informed the person was in a wheelchair when the transport was arranged. The person, who was escorted by a care worker, was then taken to the ambulance without shoes. This meant the staff had not ensured the person was appropriately dressed when going to the appointment. As the care worker was about to leave the provider told the care worker to come back from the hospital on the bus once the person had arrived at the outpatient department as they should not wait with them. The care coordinator then clarified that an

additional care worker had been added to the rota to provide cover during the appointment.

During the inspection we saw people in the lounge and in their bedrooms, did not have regular contact with staff. We saw staff regularly walked through the lounge and did not acknowledge or speak to the people that seated there. We saw one care worker who came into the lounge and sat having a drink but did not speak with or offer anyone in the lounge a drink.

People told us the staff respected their privacy and dignity when they received support from the care workers and nurses. One person said, "They make sure they dress me properly and they are quick to cover me up." We also asked the care workers and nurses how they helped people maintain their dignity and privacy when providing care. Their comments included "After the food, we divide them into two groups and give men a shave and the others a bed bath. We maintain their dignity", "I shut the door and curtains. We ask them if we can assist them and when they say yes, we go ahead" and "We don't leave the person exposed. If another staff member is on with me who speaks the person's language I will ask them to ask the person if they want a shower."

Two of the people we spoke with told us they had not been involved in the decisions about their care recorded in their care plan with a third person confirming they had been involved. The care plans were not signed by the person or their representative and the consent to care forms were not always signed and dated to demonstrate their involvement in the development of their care plan.

Requires Improvement

Is the service responsive?

Our findings

The care plans for people living at Beacon House were sometimes focused on the care tasks to be completed and not the wishes of each person as to how they wanted their care provided. Each person had a number of one page care plans which focused on a specific aspect of care for example nutrition, mobility, respiratory and circulation and skin. Each care plan included a brief summary of the person's medical diagnosis, the identified out come and a list of actions to be completed.

The daily evaluations notes, which were completed by care workers at the end of each shift, were focused on the care tasks which had been completed and not the person's experiences and interactions. This meant a complete picture of the person during the day was not recorded.

We saw records indicated nine people had DNACPR forms in their care plan folders but there was no information as part of the care plan to identify if the person wished to stay at the home at the end of their life and when they wanted their family to be contacted.

We saw the information provided in care plans was not always accurate and consistent to enable care workers to identify how they should provide appropriate care for the person.

The records for one person identified a wheelchair assessment had been carried out in June 2018 as the person was currently receiving care in their bed. The record of the assessment identified the person had been cared for in bed for two years. The outcome of the assessment was to support the person the sit in an armchair every day to prepare them for their new wheelchair. We looked at the repositioning records for the person and we saw they had not been supported to sit in an armchair since 12 July 2018. The care plan did not identify the change in the person's support needs and that care workers should transfer the person to a chair every day which meant it did not happen.

We spoke with one person who told us they wanted to have showers as part of their personal care but had been only offered body washes every day. The daily care and shower schedule displayed in the nurse's office showed this person was to have a bed bath twice a week. We spoke with the clinical lead who explained the care workers had reported the person had slipped in their wheelchair a year ago when in the bathroom so to reduce risks they had not offered the person a shower since. A referral had not been made following the incident to identify if there was any appropriate bathroom equipment which could be requested so care workers could provide safe care while providing personal care which met the person's wishes.

We asked people their views on the social/leisure activities organised by staff at the home. Their comments included "I don't like throwing balls. We used to play cards", "I usually watch television in bed" and "No activities here. They were talking about taking us to the river." One person we spoke with told us their relatives taking them out but as the person had family that was local to the home they wanted support from staff to visit them.

During the inspection we saw there was a lack of meaningful activities provided for people in the lounge

areas and in their rooms. We looked at the activities record for July 2018 and examples of activities included 'Tell the Truth day', family visiting time and ball games. The care coordinator confirmed the activity coordinator was on leave at the time of the inspection but we saw the activity record sheets which indicated what each person did during the day were completed by a care worker who was on the rota to provide care. This meant that the activity coordinator post was not a separate role and was included in the responsibilities of a care worker who was on the rota to provide care.

As part of the discussion held during the residents meeting we observed the care coordinator told people about gardening sessions which were planned to start the following week and asked for their suggestions as to what they wanted to plant. They explained people would be supported to create a garden area on the patio to the rear of the home. We raised with the care coordinator that as the first session was planned for the afternoon there was only three care workers and one nurse on duty at that time so would there be enough staff available to provide support in the home as well as in the patio area.

There were clear visiting hours displayed on the front door to the home stating people could only be visited between 11.30am and 7.30pm. This meant that people could not be visited at the time they wanted due to the time restrictions. This was discussed with the provider during the previous inspection and they agreed to change this, but as demonstrated they had not yet acted on this.

The above was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us they knew how to raise any concerns or complaints they had about their care and they would speak the care coordinator. During the inspection we looked at the record of one complaint that had been received. We saw the record included statements from staff, a referral to the GP and a response to the person's relative with the outcome of the complaint.

Inadequate

Is the service well-led?

Our findings

The provider did not operate effective systems and processes to identify, monitor and improve quality or to assess, monitor and mitigate risks.

During the inspection we found the provider had audits in place but these did not provide appropriate information to assist in the identification of areas which required improvement.

The care coordinator told us a daily audit of the medicines storage and administration should be completed by the nurse. We spoke with a nurse on duty and they were not aware that a daily audit should be completed. When we asked to review these audits, we found they had not been completed daily in line with the provider's process. There were no completed audits for 20 days during June and July 2018. The records were provided from 28 May 2018 and we saw, when completed, the nurse on duty had indicated there had been no issues identified but these records had not been reviewed by a senior staff member to ensure the audit had been completed accurately.

Monthly checks were carried out to identify if window restrictors had been fitted but these checks did not monitor if the restrictors were being used appropriately just if they were still in place. Therefore, these checks did not reduce the risks to people using the service of falling from height and did not provide useful information.

We saw the record form for the checks carried out in June 2018 to ensure the call bells were working. The records indicated some of the call bells around the home had been identified as not working but there were no actions recorded to identify what was being done to correct this and if it had been completed.

As part of the 'resident of the day' process introduced by the provider, in addition to the person's room being deep cleaned and them having a meal of their choice made that may not be on the menu for that day, the care plans and risk assessment relating to their care were reviewed. We identified that this check did not identify where information in the care plans and risk assessments was not accurate or had not been updated following a change in support needs.

During the inspection we identified the provider did not have effective arrangements to assess, monitor and mitigate risks associated with the provision of care. The provider had not demonstrated that they were providing care and treatment to people which was safe and appropriate. The risks identified included those associated with risk assessment and care plans not being updated following a change in support needs, incident and accident records not being reviewed and medicines not being managed in a safe way.

The above was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the time of the inspection a manager registered with the CQC had not been in post since November 2015. The provider told us they were considering asking the care coordinator to apply to be registered as the

manager for Beacon House.

The provider had been working with the local authority and Clinical Commissioning Group following the inspection of a second nursing home located in Southall which is also owned by the provider. Regular meetings have been held by the local authority which have been attended by the provider and representatives of any CCG's or other local authorities that fund people to receive care at the home.

People using the service told us they felt the home was well led. Their comments included "I always have to see the care coordinator. The provider doesn't have time and I don't think he is interested in any complaints or feedback", "They do as much as they can" and "She is lovely. She comes and holds my hand. She pops in and we have a long chat about how I have been. She is really nice and I know what I say to her isn't going to go any further" [This person did not identify the staff member they were referring to so we were unable to confirm if it was the care coordinator, clinical lead, a nurse or a care worker].

We also asked staff if they felt the service was well-led and their comments were mainly positive and included "Whatever the provider does he tells us what is going to happen. He is very good", "The care coordinator and the clinical lead are fine. The provider takes things for granted. He is a fake", "It is a family environment. The residents are like our family. We are fine. We are happy here. Our residents are happy" and "The house itself is a good place to work. As a non Guajarati speaker, I don't always understand what other staff are saying when they talk amongst themselves."

Staff also confirmed they felt supported by the senior staff with comments including "The provider is very good. We talk to him and he listens to us", "Mainly the clinical lead and the care coordinator, they are very supportive", "I would speak to the care coordinator first, she is very responsive and the clinical lead is also good" and "The provider is supportive. He asks me what I would like to do." We saw there were records of management meetings and staff meetings which had been regularly held.

The care coordinator told us a questionnaire had been circulated to people using the service the week before the inspection. They confirmed staff would support people if they required help to provide feedback by translating the questions and assisting in the completion of the form. A questionnaire was planned to be sent to relatives of people living at Beacon House and a feedback form was being developed for professional who visited the home.

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 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure the care and treatment of service users was appropriate, met their needs, reflected their preferences and was designed to meet people's needs by following healthcare professional advice. Regulation 9 (1) (a) (b) (c),(3)(a)(b)

The enforcement action we took:

We issued a Notice of Decision to cancel the Regulated Activities at Beacon House Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person had not supported the autonomy, independence and involvement in the community of the service user. Regulation 10 (2)(b)

The enforcement action we took:

We issued a Notice of Decision to cancel the Regulated Activities at Beacon House Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not act in accordance with the Mental Capacity Act 2005 as where service users were unable to give consent because they lacked capacity to do so, the provider could not demonstrate they followed the best interests process to make decisions for service users. Regulation 11 (3)

The enforcement action we took:

We issued a Notice of Decision to cancel the Regulated Activities at Beacon House Nursing Home.

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 registered person did not ensure care and treatment was provided in a safe way for service users. The risks to health and safety of service users of receiving care and treatment were not assessed and the provider did not do all that was reasonably practicable to mitigate any such risks. The registered person did not ensure the proper and safe management of medicines. The registered person the premises used by the service users was safe to use for their intended purpose and are used in a safe way. The registered person did not assess the risk of, prevent, detect and control the spread of infections. Regulation 12 (1) (2) (a) (b) (d) (g) (h)

The enforcement action we took:

We issued a Notice of Decision to cancel the Regulated Activities at Beacon House Nursing Home.

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 registered person did not ensure service users were protected from abuse and improper treatment and they did not have systems established and operated effectively to prevent abuse of service users. Regulation 13 (1) (2) (4) (b)

The enforcement action we took:

We issued a Notice of Decision to cancel the Regulated Activities at Beacon House Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system to assess, monitor and improve the quality and

Treatment of disease, disorder or injury	safety of the services provided in the carrying on of the regulated activity. Regulation 17 (1)(2) (a) The provider did not have an effective process to assess the specific risks to the health and safety of services users and do all that was reasonably practicable to mitigate any such risks. Regulation 17 (1)(2) (b)

The enforcement action we took:

We issued a Notice of Decision to cancel the Regulated Activities at Beacon House Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not ensure that people employed for the purpose of carrying on a regulated activity had the qualifications, competence, skills and experience which are necessary for the work to be performed by them. Regulation 19 (1) (b)

The enforcement action we took:

We issued a Notice of Decision to cancel the Regulated Activities at Beacon House Nursing Home.

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 registered person did not ensure that persons employed in the provision of the regulated activity were deployed in a way to ensure they could meet people's needs. The registered person did not ensure that persons employed by the service provider in the provision of a regulated activity had received such appropriate induction, training, supervision and assessment of their competency to ensure they were able to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a)

The enforcement action we took:

We issued a Notice of Decision to cancel the Regulated Activities at Beacon House Nursing Home.