Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

The Beeches

665 Uttoxeter Road, Meir, Stoke On Trent, ST3 5PZ

Date of Inspection: 14 December 2013

Date of Publication: January 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Management of medicines	✗ Action needed
Records	✗ Action needed

Details about this location

Registered Provider	The Beeches Residential Care Home Limited
Registered Manager	Ms. Julie Ann Edwards
Overview of the service	The Beeches Residential Care Home at 665 Uttoxeter Road, Meir, Stoke-On-Trent, provides accommodation, care and support for up to 34 people.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 14 December 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

During our inspection we spoke with eight people who used the service and three people's relatives. We also spoke with six members of staff and the registered manager. People and their relatives told us they were happy with the care. One person told us, "I like being here. I have no gripes". Another person told us, "It's wonderful here, there is a nice atmosphere". One person's relative told us, "The staff are lovely and they bend over backwards to make sure everything is right. The manager and the owners are brilliant".

We saw that people were treated with dignity and respect. People were given choices about their care, and the choices they made were respected by the staff.

People were treated with care and compassion and people received assistance with their personal care needs in a timely manner.

Effective systems were in place to ensure that people could access health and social care advice and support when they needed to. We also saw that important information about people's needs was shared with other professionals when required.

We identified that improvements needed to be made to ensure that people were protected from the risks associated with medicines. Effective systems were not in place to ensure medicines were stored safely and given when people required them.

We saw that information about people's needs and their finances was not stored securely. Improvements need to be made so that people can be assured that information about them is kept safe.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 14 January 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

Throughout our inspection, we observed people being treated with dignity and respect. We saw staff discreetly asking people if they required assistance with toileting, and we saw staff addressing people in a polite and friendly manner. Staff gave us examples of how they treated people with dignity and respect. One staff member said, "I ask people how they want to be assisted, so they are comfortable with what I am doing. A lot of the people here like to do things for themselves, so I tell them they can ask for help when they need it". Another staff member said, "I explain everything that I am doing when I assist people and I offer people choices". This meant that staff treated people with dignity and respect, and promoted people's independence.

During our inspection, we saw that staff involved people in making decisions about their care and support. We observed staff asking people what they wanted to eat and drink, and people were asked if they required assistance with their personal care needs. We saw that staff listened to and respected people's decisions. One person who used the service told us, "I get to choose what I eat every day from the menu. There are always two options at lunch time. Some people have food that's not on the menu, but I'll eat anything". This meant that people were involved in making decisions about their care and support.

We saw that people could choose and personalise their bedrooms. A visitor at the home showed us their relative's bedroom. They told us, "X chose this room themselves. We have been able to bring X's own bed, chair and television in. We were also able to put X's pictures and photo's on the walls. The owner couldn't have done anything else to make it more homely". This meant that people were involved in choosing how their bedrooms were furnished.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

Through a process called 'pathway tracking' we observed the care five people received, looked at their care records and where appropriate, we spoke with them or their relatives about their care. We also spoke with the staff about how they provided support. Pathway tracking looks at the experiences of a sample of people. This is done by following a person's route through the service to see if their needs were being met.

We saw positive interactions between the staff and the people who used the service, and we saw that people were treated in a professional, compassionate and caring manner. We saw staff reassure people when they were distressed or agitated and we saw staff respond promptly to people's needs. This meant that people received compassionate care when they required it.

The staff told us in detail about people's likes, dislikes, behaviours, risks and needs. We observed people being supported in a way that promoted their wellbeing and safety. This meant that people were supported by staff who understood how to promote people's wellbeing and safety.

Each person had a care record which contained information about some of the care and support they required. The provider may wish to note that the care and support people received was not always recorded in their care records. We asked staff how they knew what care and support people required, if the information was not always recorded. One staff member told us, "We know the residents really well. Everything we need to know is handed over to us". This meant that although staff received verbal handover's, written information about peoples care and support needs was not always available for the staff to refer to.

People and their relatives told us they were happy with the care provided. One person who used the service told us, "The girls (the staff) are so caring. Nothing is too much trouble for them". A relative told us, "We are really pleased with the care here, it's above our expectations". This meant that people and their relatives were happy with the standard of care.

Cooperating with other providers ✓ Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

When required, the staff contacted health and social care professionals for advice and support in a timely manner. Care records showed that doctors, nurses, physiotherapists and social workers were contacted when people who used the service required specialist assessment and treatment. This meant that people were supported to obtain health and social care support from other services when they needed it.

Effective systems were in place to enable the staff to respond to deteriorations in people's health. Care records showed that out of hour's doctors and emergency services were contacted when needed. This meant that staff responded to changes in people's health in the event of emergency situations.

Staff told us that a hospital transfer form was completed when a person required care and treatment at a hospital. These forms contained information about people's mobility, communication and personal care needs. Staff also told us that a copy of a person's current medicines was also taken to hospital in the event of a hospital apportionment or emergency situation. This meant that there was a system in place to share information about people's needs with other providers.

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at the way medicines were managed to check that people were receiving their medicines safely and as prescribed.

We saw that the medicines trolley was stored securely in a medication room when it was not in use. We found that the temperature of the medication was not being monitored. This meant that people could not be assured that their medicines were being stored in accordance with manufacturer's recommendations.

We checked to see how temperature sensitive medicines were stored. Refrigerated medicines are required to be stored between two and eight degrees Celsius. We saw that the minimum and maximum temperature of the medicines refrigerator was recorded on a daily basis. We looked at three months temperature monitoring records and saw that on a daily basis the maximum temperature recorded was 26 degrees Celsius. We asked staff if any action had been taken to address the abnormal temperature readings. We were told no action had been taken. This meant that there was no evidence to demonstrate that the staff had taken appropriate action to address the high temperature readings. Following our inspection the provider contacted us to inform us that the maximum temperature readings were due to an error with the refrigerator's settings. They told us that action had now been taken to address this error.

Staff told us that people's prescribed creams were stored in the medicines trolley. During our inspection, we saw that one person's prescribed cream was stored on a shelf in their en-suite bathroom. This person was known to walk unsupervised at times and was often confused. This meant that this person was at risk of accessing their prescribed cream unsupervised which could result in harm.

We observed people receiving their medicines during the morning and afternoon. We saw that people were encouraged to take their medicines and people were reassured about the reasons for taking their medicines. We also observed people having eye drops and inhalers administered in communal areas in front of other people. This meant that people's

privacy and dignity was not always maintained during medicine administration. Following our inspection we were contacted by the provider, who informed us that after our inspection, people who used the service were consulted with and were are happy with this practice.

During a medicines administration round, we heard one person ask if they could have their medicines as they were in pain. The staff member told them, "You can, when I get to your name". This person waited 20 minutes before they received their medicines. This meant that staff were not responsive to the person's pain and they had to wait to receive their pain relief medication.

We stopped a member of staff from administering one person's morning medicine as their medication administration record (MAR) showed that they had already taken this medicine. The staff member told us that they had signed the MAR earlier in the morning in error, and they assured us that the person had not already received this medicine. This meant that MAR was inaccurate and if another staff member had been required to take over the medicines administration round, the person was at risk of not receiving their prescribed medicines.

We saw that people were mostly prescribed their morning medicines to be taken at breakfast time. The morning medicines round ended after 11:40 am. We saw one person was given their prescribed morning medicines at 11.30 am. This medicine required a four hour gap in between doses. The MAR recorded that this medicine had been given at 8 am. This meant that no accurate written record of the time of this medicine administration was recorded. On the day of our inspection, the lunch time medicines round began at 1:50 pm. The same staff member who administered the morning medicines round also completed the lunch time medicines round. They did not offer the person their prescribed medicine because the four hour gap had not been achieved. They said, "I can't give this now as I only gave it two hours ago". This meant that the staff member had remembered it was not safe to give the medicine, but if this staff member had been unavailable to complete the lunchtime medicines round, the staff who were responsible for administrating medicines would not have known that the four hour gap had not been achieved. This meant that the person was at risk of having their medicines administered in an unsafe manner.

We asked the staff member when the person would be offered their lunchtime medicines. They told us, "I will hand over to the late staff to try and give it later". We observed the handover and saw that this information was not handed over to the staff member who was responsible for medicines on the late shift. We told the staff member who was responsible for medicines on the late shift that the person had not been offered their lunchtime medicine. They said, "It should have been handed over to me'. This meant that the handover systems were ineffective and information about the person's medicine needs had not been handed over.

Some people needed 'as required' medication. There were no protocols or guidance in place to guide staff to ensure that the most appropriate medication was given at the most appropriate time. There was also no system in place to record the number of 'as required' tablets given, if the person was prescribed one or two tablets. This meant that we could not be assured that all staff were administering 'as required' medicines in a consistent manner, and there was no accurate record of how many tablets people had taken if they were prescribed variable doses.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We checked to see if information about people was kept secure. We saw that the care records were stored in an unlocked trolley in the reception area of the home. Completed incident forms, which recorded information about people, were stored on a shelf in the reception area. Some people's opened private and confidential mail was easily accessible in the reception area of the home. This included one person's bank statement. This meant that people could not be assured that information about them was stored securely at the home.

We also saw that three people's prescription scripts were readily accessible in the reception area of the home. This meant that people's prescription scripts were not stored securely and peoples' prescriptions could have been lost or damaged.

We looked at five people's support plans and we saw that the support plans did not always reflect the care that people received. For example, one person who used the service required hourly assistance to enable them to access the toilet. We saw that this person received this support, but their support plan did not record that this was the agreed plan. Two people's daily records showed that they had poor sleep patterns and they had a tendency to walk around during the night. The daily records showed that the night staff appropriately supported these people, but their support plans did not contain information and advice to guide staff in how to consistently support these people. This meant that if new or temporary staff were needed to work at the home in the event of a staffing emergency, the required information about the care and support people required would not be available, and people would be at risk of receiving unsafe or inconsistent care.

During our inspection, we found a number of concerns which related to the recording of medicines. We checked to see if effective recording systems were in place to protect people from the risks associated with medicines. We looked at four people's medication administration records (MAR) and saw that all three of the four MAR's contained gaps. A gap on a MAR means that there is no record that a medicine has been administered. This meant that people could not be assured that they had received their prescribed medicines.

We attempted to complete an audit of the four people's boxed medicines to check that accurate stock records were kept. We were unable to complete this audit as accurate records were not kept. This meant that the home could not account for the numbers of medicines on site.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: Effective systems were not in place for the safe storage, administration and recording of medicines. Regulation 13
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: Accurate records in respect to people's needs and medicines were not kept. Regulation 20(1)(a) Care records and other information relating to people was not stored securely. Regulation 20(2)(a)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 14 January 2014.

CQC should be informed when compliance actions are complete.

This section is primarily information for the provider

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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