Techscheme Limited

Bluebell Nursing Home

Inspection report

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17 February 2017

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on16 and 17 February 2017. Bluebell Nursing Home is registered to provide accommodation and nursing care for up to 51 people. During the inspection 43 people were being accommodated. We were advised when the home is full it accommodates 49 people as some double rooms are being occupied as single rooms.

The service had a registered manager. 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.

The service was last inspected in July 2014 and at that time the service was rated overall good, with good in all five domains.

People told us they felt safe living at Bluebell Nursing Home. Staff understood the principle of keeping people safe. Risk assessments were in place to ensure staff were aware of how to minimise risks for people. Staffing levels met the needs of people, with the home having a long - standing staff group. Staff told us they felt well supported by the management team. They received support and on-going development through reviews and an annual appraisal with the management team. There was an extensive training programme, with training arranged when the need arose. Recruitment checks had been completed before staff started work to ensure the safety of people. Medicines were administered and stored safely.

Staff had a basic knowledge of the Mental Capacity Act and people were not being restrained other than to keep them safe. People enjoyed their meals and were offered a choice at meal times. People were supported to access a range of health professionals.

Before people moved into the service an assessment of their needs was undertaken. Care plans had been completed which explained how people wished to be supported and care needs were monitored and reviewed to ensure the care given continued to meet people's needs. People felt confident they could make a complaint and it would be responded to. Complaints were logged and there were recordings of investigations into complaints.

People felt the staff were caring, kind and compassionate. The home had an open culture where staff felt if they raised concerns they would be listened to. Staff felt supported by the management team and were clear about their roles and the values of the home. The management and staff team strove constantly to improve the quality of the service people received by ensuring people were at the forefront of making decisions which affected them. There was a good quality assurance process which ensured a good quality service was provided to people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe living at Bluebell nursing home. Staff were aware of how to recognise signs of potential abuse and were clear about the action they would take to prevent people from harm.

Recruitment procedures were in place to ensure staff were suitable to work with people at risk.

Staffing levels were planned to ensure the needs of people could be met.

Medicines were managed safely and people received their medicines on time.

Is the service effective?

Good

The service was effective.

Staff had a basic knowledge of the Mental Capacity Act 2005,

Staff received a range of training and support which enabled them to do their job safely and effectively.

People told us they enjoyed their meals and there was plenty of variety on offer.

People were supported to attend health and other appointments as required and timely referrals were made to health care professionals.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were, kind and compassionate.

The culture of the home was for people to be at the centre of decision making.

People were supported by caring staff who respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People were supported by staff to take part in a range of activities available both individually and in a group.

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Care plans were personalised and recorded how the person communicated their wishes and how to support people with managing their emotional wellbeing.

People and families were involved in how they wished their care to be delivered and their preferences for this.

There was a complaints procedure in place and people told us they would raise any concerns with the management team.

Is the service well-led?

Good

The service was well led.

Staff felt well supported by the management team.

People were involved in how the home was run and their views were sought to improve the service.

There were regular quality assurance audits which, where shortfalls were identified, were addressed in a timely manner.

Bluebell 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.

An inspector and Specialist advisor spent two days in the home and one expert by experience carried out this inspection which took place on 16 and 17 February 2017. The first day of the inspection was unannounced. An expert by experience is a person who has personal experience of either using, or caring for someone who uses this type of service.

Before the inspection we reviewed the information we held about the service. We read the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

Some people living in the home were not able to tell us what they thought of the service. We therefore observed the care provided, to help us understand their experiences. We spoke with the registered manager, two members of the operational management team, deputy manager, nurses senior and other care staff, housekeeping, the chef and kitchen assistant.

We spoke with nine people who used the service and five relatives. We also spoke with the director, operations manager, registered and deputy manager, the training officer, three nurses five care staff, the cook and kitchen assistant, the mental capacity lead, a health professional who was visiting the home and two external training professionals. We reviewed eight care plans and the associated risk assessments and records. We looked at four staff recruitment files and other documents relating to staffing. In addition we reviewed documents relating to the management and running of the home.

Good

Is the service safe?

Our findings

People felt safe living at the home. They told us they felt protected from the risk of abuse and from environmental hazards. We observed that they all had their call bells within reach to summon help if required. One person said, "If I want any help I ring my buzzer and they come at once. They (staff) come around at night and look in. I don't worry about things I used to at home, I like have I locked my door". People and relatives we spoke with thought there were enough staff on duty to care for them safely. One person said, "There is always someone popping in to see if you want anything. If I have to press my bell they usually come very quickly". All of the people we asked said that their medicines were well managed by the staff and said they received their medicines on time.

Peoples care plans had detailed associated risk assessments to reduce the risk of harm. The risk assessments identified potential risks individual people may be susceptible to, such as mobility, dehydration or health related risks. The risk assessments gave clear guidance to staff on how to reduce the risks. Staff were aware of the associated risks to people and what care they needed to give to ensure the risks were minimised. Each person had a personal evacuation plan which gave staff guidance on what support the person would need in the event of an evacuation such as in a fire.

People and relatives told us they believed people living in the home were safe. The home had policies relating to safeguarding and whistleblowing which staff were aware of and had the knowledge of what action to take and agencies to report to if they had concerns. Staff had received training to support this knowledge.

Accidents and incidents were monitored and risk assessments reviewed to ensure all aspects had been considered. The monitoring included looking after individuals following an event and looking for emerging patterns for example the environment or the times of events. This information was audited on an on-going basis and formed part of the development of people's care plans.

Measures were in place to maintain standards of cleanliness and hygiene in the home. For example, there was a cleaning schedule which housekeeping staff followed to ensure all areas of the home were appropriately cleaned. We found bedrooms and communal areas were clean and tidy. The equipment which people used was kept clean through a schedule of decontamination and regular checks were carried out to ensure wear and tear and necessary repairs on equipment were completed.

There was enough qualified, skilled and experienced staff to meet people's needs. Staffing levels were planned and sufficient to meet the needs of people and duty rotas reflected this. People and relatives told us they had a good relationship with staff. All staff spoken with had worked in the home for a lengthy period of time. They told us there was always enough staff on duty to meet people's needs and they did not have to rush. They advised us they supported each other and worked well as a team.

Recruitment records showed relevant checks had been followed to keep people safe. Application forms had been completed and where available staff's qualifications and employment history including their last

employer had been recorded. Photographic evidence had been obtained ensuring staff were safe to work with people. Staff were subject to a Disclosure and Barring Service (DBS) check before new staff started working. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults. Staff confirmed they had been through a good recruitment process before they had started working in the home.

People advised us they received their medicines on time and in a place of their choosing. Medicines were administered safely and there were clear protocols in place for the administration of PRN medicines [medicines which are taken as and when required]. Stock levels tallied with the medicine administration records [MAR] and medicines were disposed of according to the provider policy. Where errors had been identified such as via a pharmacy inspection, steps were taken to address these. For example, reflective meetings were held to review how the error had occurred and what action was required to minimise the risk of further occurrences.

Good

Is the service effective?

Our findings

People and relatives told us they thought the staff were trained to meet their needs. One person told us, "The staff are well trained and if they don't know they go and ask the nurses". A relative said, "They (staff) are very professional and the level of skill and care is very high. They know how to communicate with my mum [who has dementia]. They face her and get down to her level and speak very calmly". People told us they enjoyed their meals and had a choice. People were supported to maintain good health. One person told us, "I have had several chest infections and the GP comes in. I also had to have an X-ray at the hospital recently. The nurse arranges everything".

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.

Staff had knowledge of the Mental Capacity Act and there was a member of staff who had responsibility for ensuring this was understood in the home. People's records recorded some people had pressure mats placed by their bed to alert staff to when they moved and some people had bedside rails to keep them safe when in bed. These were for people's safety, but there was no evidence people had been assessed or consulted regarding their capacity for their consent to use bedrails and pressure mats. Staff reassured us these were used to keep people safe and not as a restraint. The provider and registered manager advised us they would ensure people's records included information on people's capacity and record best interests meeting, involving others in these decisions where appropriate. On the second day of the inspection the provider had already received information from the local authority regarding assessing people's mental capacity.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application 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. We found applications had been made appropriately for people. Details of these applications and where decisions had been made these were recorded in people records.

The home employed a training lead, who as well as providing training spent a large time working with staff in the home. They advised this allowed them to ensure staff were putting into practice what they were learning. Following the inspection the provider sent us their training matrix which was used to record the training staff had undertaken, when the training was due for renewal and when it had expired. This demonstrated staff underwent a large programme of training. A range of training methods were used, from

on-line to more practical face to face training. Staff told us they found the training to be good and equipped them to do their job safely and effectively. We spoke with two external visitors who were providing training independently. Both confirmed the director supported staff in attaining skills and gaining qualifications. Specific training had been found when a person came to the service, which staff had not had prior training in the area of their diagnosis. The management team were aiming to introduce 'Champions' which would involve staff promoting standards in various aspects of care such as in falls, dementia and care and dignity. New staff underwent an induction programme, which worked towards the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Staff had regular supervision. Records showed these were on a regular basis and staff felt supported. Staff had regular meetings and recording of minutes showed staff were able to make suggestions and raise concerns at these meetings.

People were happy with the food and drink on offer at the home. One person said, "I don't like to eat a lot and if I don't like it I won't eat it. You can have what you like though". Another person said "The food is good but I can't manage two dinners and I have sandwiches in the evening. They give me a variety and I can ask if I don't like it and have what I want". However another person said, "I don't really like the food; the cook does come in daily and ask you what you want, so they do me something else". People could choose to eat in their room or in the dining room which was attached to the kitchen. We observed staff supporting people to eat and drink in all areas. Support was given in a patient manner and allowed the person to eat at their own pace. Staff sat at the person's height and made eye contact with them. All meals were cooked using fresh ingredients and the kitchen had a good knowledge of people's dietary needs and abilities. Specialist equipment had been bought to ensure people's needs could be met. For example bowls which kept food warm had been provided to ensure people who were slow eaters had their meals kept warm until they finished their meal. A relative told us, "The kitchen staff know mum's likes and dislikes. Like today she doesn't like liver, so they offer an alternative".

People's care records contained a section dedicated to eating and drinking which recorded nutritional status and dietary needs such as the need for fortified or pureed food, swallowing difficulties and assistance required to eat and drink. People's weight was monitored and recorded monthly and where people's weight had changed, remedial action was taken and a referral to the appropriate health professional was made and a management support plan put into place.

People had access to a range of health services such as the dentist and the optician and the service supported people to attend hospital appointments if required. The service ensured that timely referrals were made to health and other professionals to maintain people's health and well-being. One person told us, "I was very unwell and had lost a lot a weight. The carers weigh me every month and it is staying stable now". All of the people we spoke with said they would have access to healthcare services if they needed them. A relative told us, "The nurses are very good and notice things. When mum gets signs of water infection, we know the tell-tale signs. They call in the GP and let us know.

Good

Is the service caring?

Our findings

Staff were kind, caring and compassionate. All the people and relatives were positive about the care and support they received from staff. One person said, "I am very happy here. The staff are very friendly and always popping into my room to see me". Another person told us "It's like home from home; you don't have to ask for anything". A third person said, "We have a good laugh together. Also when they talk to me they talk to me as a person".

Staff were knowledgeable and understood people's needs. Staff explained what they were doing when they supported people and gave them time to decide if they wanted staff involvement or support. Staff spoke clearly and repeated things so people understood what was being said to them. Staff had a good knowledge of people and knew how to care for them. For example we found one person who looked distressed. When we explained this to staff they knew exactly what this meant for the person and assisted them in a caring and patient way. An activity took place in the home which was regarding spring flowers. As all people were not able to join in the activity the flowers and the arrangements were taken on a trolley to everyone's room, so they could be included in the activity. One person who had been included also wanted to take the flower arrangements around to see people. The activities co-ordinator and volunteer ensured this happened without any fuss in a timely way. People were asked before the flowers and people went into their rooms, which was an enjoyed social interaction by many people. On display in the home was another activity which had tried to include everyone. This had been arranged to celebrate Valentine's Day. People had been asked to recall something about love, which had been written on a heart shaped card. These had been placed on a small artificial tree which was on display in a communal area of the home.

Staff tried hard to ensure people and their relatives could express their views. A family member told us, "They (staff) are amazing here and can't do enough for you. They treat me as part of the home as well. Sometimes I get depressed about [relatives] situation and they are always good to me and very supportive. Everyone is so friendly. I wouldn't want [relative] to be anywhere else". Another relative said, "They are lovely here and we are treated like part of the family. Feels like we are coming to [relatives] home, [relative] feels like it's her own home". We observed care in communal areas throughout the day there was good interaction between people and staff who consistently took care to ask permission before intervening or assisting. We saw staff were happy, cheerful and caring towards all the people and their relatives. When we spoke with one person, staff discreetly advised us the person has a sensory impairment which made it difficult for them to hear. They gave us a booklet which had pictures of certain words and emotions which helped the person communicate.

People's preferences, likes and dislikes had been recorded in their care records. The most important of these had been condensed and displayed on cards or notices in people's rooms. A relative said, "Mum doesn't like male carers. They listened to that and wrote it in her notes. Now when she needs care and the male carer comes in, they go and get another carer to help". People told us they felt involved in their care. One person said, "I stay in bed mainly but the carers ask me in the morning if I want to get up and I can say ok or not, it's my choice". Another person said, "At night there is a carer who gets me really comfortable and knows just how to position my legs and I have a really good night sleep".

We observed how staff made sure people's dignity and privacy was respected. For example, by knocking on doors before they entered and closing doors and curtains before commencing with personal care tasks. Staff confirmed they understood and valued the need to respect people's privacy and dignity. They described the methods they used when supporting people with personal care. People had decorated their room with their own furniture and items which were personal to them and each room reflected the person's interests and character as much as possible. People had been consulted on their views on their care and privacy and dignity through resident's meetings and surveys which had happened on both a group and individual basis to ensure all people were included. The analysis of this information showed people were very satisfied their privacy and dignity were respected.

Staff received training in end of life care and the community matron supported people and staff with end of life care. The service made sure advanced care planning took place therefore avoiding unnecessary hospital admissions, and end of life care plans were implemented when treatment became palliative. Some of the compliment cards echoed the sentiment of families for the support they had during their bereavement and for the care of their relatives.

Good

Is the service responsive?

Our findings

People and relatives told us the service was responsive to their needs. A relative told us, "They always include us and listen to our suggestions. For example Mum seems to cope better with a small plastic cup for her drinks and they have introduced that now". People were happy with the social options available and that they had a choice of whether to join in or do their own thing. One person said, "I like to listen to my radio. I don't get bored as people pop in and we have things going on. We had a lovely Christmas party and different singers. Yesterday we had an accordion player here. There is a notice board with the events on and they come and tell me".

Pre admission assessments were undertaken before people moved into the home to ensure the person's needs could be met. From these, care plans were developed and reviewed to include all a person's need, preferences and choices. Plans included information on maintaining people's health, likes and dislikes and their daily routines and how these should be met. Plans included potential risks to the person and management plans were devised to minimise these risks such as, mobility, pressure ulceration, epilepsy and risk of malnutrition and dehydration. Staff told us they felt there was sufficient information and guidance to be able to support people safely and in the way they wished. Care plans were in place on how the person communicated their wishes and how to support people with managing their emotional wellbeing. Care plans were regularly reviewed in consultation with the person, their representatives and their key worker to ensure they were up to date and met their needs accordingly. Where any changing care needs had been identified they had been documented in their care plan and communicated with the staff team. Relatives told us the service responded well to their relatives changing needs. One relative told us, "My [relative] had been going through a particularly bad patch where [relative] would become quite frustrated and verbally and physically aggressive. The care staff were excellent in how they dealt with it. The GP was called and there was a review of their medication. Another relative said, "When [my relative] was able to sit out it was difficult for [my relative] to get comfortable in an ordinary arm chair so the staff organised a special chair"". These examples demonstrated the service was responsive to ensuring people's needs were met.

A full time activities co-ordinator and a volunteer organised activities in the home. They divided their time between group activities and one to one activities. A newsletter was published regularly keeping people and relatives informed of events. Visitors could visit at any time and people had free access to a handheld telephone, emails and skype. A 'mobile shop' visited people twice weekly and orders were taken for any particular item.

The home had introduced 'Namaste' programme, which focused primarily on individuals with advanced dementia, and often nearing their end of life. Three staff had attended a training course and a 'Namaste' room had been created with a reminiscence theme. The programme offered a quality period of time with a person, when an individualised care plan could be used to promote communication and self-esteem on a sensory level. We were told people had responded positively to the programme.

The service had a complaints policy and procedure and people and their relatives were aware of the complaints procedure and how they would address any issues people raised. All of the relatives and

representatives we spoke with said they knew how to raise concerns and their opinions were listened to. One person told us, "I would get my relatives to the owner". Another person said, "I would have a word with the governor (Director), he is always around". A relative told us, "I would have no hesitation to say something. Things get dealt with straight away. For example when mum first moved in we thought the room was bit dark. We spoke to the owner and they put in an extra light". A health professional told us, "Staff are lovely, I enjoy coming here, staff are helpful and they can answer any questions I ask. The care plans are good and that information is generally in there." Records of complaints were held and these were investigated and responded to within the services timescales in their policies.

Good

Is the service well-led?

Our findings

People and relatives thought the home was well run. One person said "It is very well run. There is never any trouble and it seems a happy place". A relative said, "The manager is very good. When I first came to see the home I was really impressed with her caring manner and her understanding".

The management team at the service included the company director, registered manager, operations manager and a lead nurse. In addition the training officer, deputy matron, housekeeper and cook had a supervisory role. The management team worked closely together and there was clear leadership within the home. People, visitors and staff spoke positively about the leadership and the culture of the home. All staff felt part of one team and they were working towards the same goals. Staff were aware of the whistle blowing policy and had confidence they would be listened to and their information respected. The results from the staff survey showed they thought the home was well run and the conduct of all staff was good. The registered manager was aware of her responsibilities and submitted notifications to us appropriately and in a timely fashion. Staff told us the management team were always available if they needed to speak to them. Staff were aware of the homes values and were clear people were at the heart of all decisions.

The service had a positive and open culture. The management team listened to any suggestions people or staff had around how they could improve the quality of the service and staff told us they were encouraged to come forward with ideas. The management team actively encouraged staff to develop their full potential and would support them to achieve this. One of the external training officers supported this, advising the management are always supporting staff to extend their training and learning. The management team recognised the importance of supervision and appraisals for all staff and saw these as a key element to staff management and development of staff. To keep up to date with best practice, the registered manager accessed resources and information from agencies such as the CQC, National Institute for Clinical Excellence, the Social Care Institute for Excellence and Age Concern.

The operations manager had introduced new quality assurance processes to ensure the service gathered as much information as possible to ensure people's needs were being met. This included monthly and quarterly audits which covered areas such as record keeping, environmental safety, staff training and supervision, care plan reviews and people's views, management of medicines and incident recording. The audits showed that the service used the information they gathered to improve and enhance the quality of care people received. During the inspection we noted some people's daily recording of for example, fluid intake or the appliance of topical creams were not up to date. When we spoke with staff regarding these records, it was clear this was a recording issue and that people were receiving the care they needed. When we spoke to the management team regarding this issue they were already aware. They were able to show how and where the issue of recording had been discussed with staff. Also in response to this issue the management team had already arranged training for staff to demonstrate the importance of maintaining accurate records.