Czajka Properties Limited

Beanlands Nursing Home

Inspection report

Colne Road
Cross Hills
Keighley
West Yorkshire
BD20 8PL

Tel: 01535633312
Website: www.czajka.co.uk/beanlands.html

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 7 and 8 February 2017 and was unannounced. A previous inspection, undertaken in October 2014 found no breaches of legal requirements.

Beanlands Nursing Home is registered to provide nursing care for up to 45 people who may have a physical disability, terminal illness and require respite care or a period of convalescence. Some people at the home are also living with dementia. Facilities are spread over two floors and include accommodation in single or potentially twin rooms. The home is set in private gardens in a residential area on the outskirts of Cross Hills, Yorkshire.

The home had a registered manager in place and our records showed she had been formally registered with the Care Quality Commission (CQC) since December 2015. A registered manager is a person who has registered with the CQC 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 told us they were safe living at the home and staff had a good understanding of safeguarding adults procedures. We found a range of safety issues at the home including issues regarding window restrictors, open sharps boxes, laundry facilities that were not secure from the public and open store rooms. Some people had bedrails without covers in place, meaning there was a risk of entrapment.

Maintenance of the premises had been undertaken, although records were not always signed to confirm they had been completed appropriately, and checks had failed to identify the safety issues highlighted at the inspection. We have made a recommendation about this. People had emergency evacuation plans in place. Accidents and incidents were monitored and reviewed to identify any issues or concerns.

Suitable recruitment procedures and checks were in place, to ensure staff had the right skills. All staff had been subject to a Disclosure and Barring Service check (DBS). People and staff members told us there were enough staff at the home, although said it could be busy at times. We have made a recommendation to the provider about how they assess staffing numbers and care needs. We found issues with the management of medicines at the home, particularly around the use and recording of topical medicines, such as creams, and variable dose medicines.

Staff told us they had access to a range of training and updating, and records confirmed this. They told us they also received annual appraisals and regular supervision. People told us, and our observations confirmed the home was maintained in a clean and tidy manner.

People's health and wellbeing was monitored and there was regular access to general practitioners, dentists and other specialist health staff.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. The registered manager confirmed applications for DoLS had been made or granted. It was not always clear appropriate action had been taken, in line with the MCA, to obtain consent or determine action in people's best interests, where they did not have capacity. People were asked their consent on a day to day basis.

People were happy with the quality and range of meals and drinks provided at the home. They told us they could request alternative items. Special diets were catered for and kitchen staff had knowledge of people's individual dietary requirements.

The environment was not always suited to supporting people living with dementia or a cognitive impairment. We have made a recommendation about this.

People told us they were happy with the care provided. We observed staff treated people patiently and with due care and consideration. Staff demonstrated a good understanding of people's individual needs, preferences and personalities. People and relatives said they were always treated with respect and dignity. They told us there were meetings at which they could express their views.

Care plans were detailed and related appropriately to the individual needs of the person. A range of activities were offered for people to participate in. Records suggested activities for people living with dementia were not always individualised to their particular needs. We have made a recommendation about this. The registered manager told us there had been one formal complaint in the last 12 months. Some relatives suggested responses to concerns were not always timely.

The registered manager told us regular checks on people's care and the environment of the home were undertaken. However, these checks and audits had failed to identify the issues we noted at this inspection, particularly around safety issues and topical medicines. Staff felt well supported by management, who they said were approachable and responsive. The provider had sought people's views through the use of quality questionnaires, although these were not always well completed. Records were not always well maintained or up to date.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the Safe care and treatment, Need for consent and Good Governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Records around the use and administration of topical medicines and variable dose medicines were not clear. Safety checks at the home had failed to identify a range of safety risks. Individual risk assessments had not always been reviewed.

Staff had undertaken training with regard to safeguarding vulnerable adults. Accidents and incidents were recorded and monitored.

Recruitment processes were in place to ensure appropriately experienced staff worked at the home. People said there were enough staff to me their needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always understand the concept of best interests decisions and the provisions of the Mental Capacity Act (2005). Formal consent requirements were not always clearly recorded. DoLS applications had been made appropriately.

Records confirmed a range of training had been provided. Annual appraisals and supervisions had taken place.

People were offered choices. They had access to a range of meals and drinks and specialist diets were supported. People's wellbeing was supported through regular contact with health professionals.

Is the service caring?

Good

The service was caring.

Relationships between people and staff were friendly and reassuring.

People told us they were happy with the care they received and said they were well supported by staff. There was some evidence

people had been involved in determining the care they received.

We observed staff supporting people with dignity and respect in a range of care situations. People were supported to maintain their independence. Where appropriate, people had detailed how they would like to be cared for at the end of their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Assessments of people's needs had been undertaken and care plans reflected these individual needs.

There were a range of activities for people to participate in. Activities for people living with dementia were sometimes limited. People told us they could make choices about how they spent their days or the care they received.

The provider had a complaints policy in place and people were aware of how to raise any complaints or concerns. Recent formal complaints had been dealt with appropriately. Some relatives said responses to concerns were not always timely.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

A range of checks and audits were undertaken on people's care and the environment. However, these checks had failed to identify the issues we noted at this inspection. Questionnaires had been used to gather people's views, although these were limited.

Staff were positive about the management of the home. They said they were happy working at the home and that there was a good staff team.

Records were not always up to date and did not always contain sufficient detail.

Beanlands 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.

This inspection took place on 7 and 8 February 2017 and was unannounced. This meant the provider was not aware we were intending to inspect the home.

The inspection team consisted of one inspector, a specialist adviser (SPA) and an Expert by Experience (ExE). A SPA is a professional with particular qualifications or extensive background in certain aspects of the service type inspected. An ExE is a person who has personal experience of using or caring for someone who used this type of service.

Before the inspection, the registered provider completed a provider information return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the home, in particular notifications about incidents, accidents, safeguarding matters and any deaths.

We spoke with four people who used the service, five relatives and one friend of a person who used the service, to obtain their views on the care and support received. Additionally, we spoke with the registered manager, senior manager, deputy manager, care co-ordinator, maintenance manager, one nurse, three care workers and the chef.

We observed care and support being delivered in communal areas and viewed people's individual accommodation. We reviewed a range of documents and records including; five care records for people who used the service, nine medicine administration records (MARs), three records of staff employed at the home, complaints records, accidents and incident records and a range of other quality audits and management records.

Requires Improvement

Is the service safe?

Our findings

On arrival at the home we spent time looking around the building and noted a number of safety issues. Windows at the home did not have window restrictors that met the current Health and Safety Executive (HSE) guidance for window restrictors in care homes. A window in one person's room was found to have had the restrictor removed, meaning the window could be opened wide onto a long drop. We spoke with the maintenance manager about this. He told us the window had been replaced and had not been aware there was no restrictor on this window. By the end of the second day of the inspection a new restrictor was fitted to this window. The manager and provider said they were not aware the restrictors in place did not meet current HSE guidance and would review the whole home as soon as possible.

Open sharp boxes were stored on medicine trolleys kept on landings or in lounge areas. These boxes contained small needles used to help test people's blood. This posed an infection risk if people suffered a needle stick injury through handling these items. We also saw clean medicine pots, ready for use when medicines were administered, were stored on top of the trolleys in the corridor leaving them open to be handled by people passing, posing an infection risk. The registered manager said these would be removed.

The laundry for the home was accessible from a public corridor via a fire exit route. There was no lock on the laundry door. We noted a range of cleaning chemicals were freely available in the laundry. This meant there was a risk people could be harmed if they touched or drank these chemicals or there was a risk they may become trapped in the laundry machinery. The provider advised action would be taken to fit a lock to the laundry door.

We found a number of store rooms were left open and were accessible from public corridors. One store room had a sign stating, 'Fire door – keep locked', but was open throughout the inspection period. A bathroom / toilet area, in the process of being refurbished, contained a range of stored equipment items. However, this room had not been locked during this period of refurbishment, and was accessible to people who lived at the home, and there was no signage to say the area was out of order or not in use. Because the room was not secured this presented a potential safety or trip hazard to people who may still enter the room thinking it was still a functioning facility.

During the inspection we noted two people were being supported in bed and had bedrails in place to ensure they were safe and did not inadvertently fall out of bed. We saw these people only had bedrail covers on one side of the bed. There was a gap between the top and the bottom bedrail meaning there was a risk the people may become trapped in between the rails. We were subsequently informed this was a temporary omission and that bedrail covers would normally be in place.

The provider told us all these issues would be addressed immediately.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment.

People's care records contained copies of risk assessments related to the care they were receiving. These risk assessments related to matters such as risk of falls, risks associated with the use of bedrails and nutritional intake. We found these risk assessments were not always reviewed in a timely manner. For example, we saw one person's falls risk assessment had been updated in May 2016, and their risk had been re-elevated from medium to high, after a number of falls. There was no further review of risk after this date. The same person had a bedrail risk assessment which had been last updated in September 2015. The individual's care plan for the use of bedrails stated the risk should be reviewed every six months. This meant risks related to people's care were not always reviewed and updated in a timely manner.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment.

We looked at how medicines were managed at the home. We examined people's medicine administration records (MARs). We saw records contained important information, such as any allergies they may have to certain medicines. There were minimal gaps in MAR recording and codes had been entered to show a person had refused or had not required a certain medicine. Some medicines were prescribed as a variable dose. For example, some pain relief medicines were prescribed as, 'take one or two as required'. We noted the number of tablets given was not always recorded meaning it was not always possible to be certain of the dose people had been given. Two people were prescribed a thickener to be added to their drinks because they had swallowing difficulties. Such thickener is a known choking risk if swallowed directly. We found several tins of thickener freely available in people's rooms or stored in unlocked wardrobes.

Where people were prescribed topical medicines there were no signatures included on the MAR to say these had been applied. Topical medicines are those applied to the skin such as creams or lotions. We asked senior staff members how topical medicines were managed. They told us care workers completed topical medicines records when they applied them during the delivery of personal care. We looked in people's rooms and found these records were extremely poorly completed. The majority of records had no signatures to say the creams had been applied. Where records had been completed, these often related to several months previously, with last entries in some cases being June or July 2016. This meant we could not be certain creams and lotions were being correctly and regularly applied. We also found creams stored in people's room were not dated when they had been opened. One cream in a person's room had a pharmacy label date of June 2016 and no date when the item had been opened. The instructions on the medicine stated any unused cream should be discarded three months after opening. This meant we could not be certain creams remained effective and safe to use.

We spoke with the registered manager and the provider about this. The registered manager told us they were aware there were difficulties in ensuring care staff completed topical medicine records and they were looking to address this.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment.

A number of people living at the home were supported to take controlled drugs as part of their care. Controlled drugs are medicines that are required to be stored and monitored in line with particular legal requirements. We checked these medicines with one of the nursing staff at the home. We found the medicines were stored correctly and records regarding their use and stock numbers were up to date and correct.

Checks were carried out on equipment at the home. We saw routine maintenance checks were undertaken

on fire equipment, nurse call systems, emergency lighting, fire doors and fire exits. The home had a legionella assessment and asbestos assessment in place and we saw copies of the home's gas safety certificates and five year fixed electrical system certificates. We were shown copies of portable appliance testing (PAT) records for small electrical items in use at the home. We noted these records were not signed or dated by the person carrying out the test, meaning it could not be immediately verified the person undertaking these checks was suitably qualified to do so. We spoke with the maintenance manager about this. He agreed this was an error when the checks were completed. He agreed this matter should have been identified and assured us checks had been undertaken by a competent person. He said the issue would be addressed immediately.

We recommend safety records for the home are appropriately signed, dated and checked.

People told us they felt there were enough staff at the home, although it was busy at times, particularly when staff called in sick. People told us, "That would be one of the main criticisms, they do seem short staffed a lot, though they all help when needed" and "Weekends, there are fewer staff around and it's not always the regular people." Staff told us there were usually seven care staff rostered for the morning shift and six care staff for the afternoon shift. They told us this sometimes could fall to five. The registered manager confirmed the staffing compliment should be two nursing staff and seven care staff in a morning and six care staff on an afternoon shift. We examined the duty rotas for the home. We noted that on most days there were seven and six care staff rostered, although on some occasions this number fell to four. The registered manager told us these were prospective figures and, where necessary, additional staff were then brought in to boost the figures. She told us where agency staff were used then they tried to ensure the same staff were used, to provide consistency of care.

The registered manager and senior manager told us they had identified meals times were often a busy period for the home. To deal with this they had established an overarching care worker role between 8.30 and 5.00pm. However, on the first day of the inspection we noted only one care worker was available for the majority of the lunch period in the dining room and supervision of the lunchtime was not always consistent. The registered manager also told us staff were employed to work flexibly in the home, so care workers could cover the laundry or domestic shifts, if the need arose. On the second day of the inspection we saw the care co-ordinator was working an additional shift to cover the laundry. The registered manager told us she used a dependency tool, completed quarterly, to help determine required staffing levels, but this was being reviewed across the organisation. We examined the last available dependency tool for the home, dated December 2016, although it was not clear from the information gathered how this was translated into staffing hours or numbers.

We recommend the provider establishes a robust system to ensure staffing levels relate to the assessed needs of people living at the home.

At the previous inspection in October 2014 we had found appropriate recruitment procedures were followed at the home. At this inspection we found the home continued to carry out appropriate checks on staff before they were employed, including, two references, identity checks and Disclosure and Barring service (DBS) checks. Where any historical items had been highlighted as part of DBS checks then an appropriate risk assessments had been undertaken.

People and their relatives told us they felt safe living at the home. Comments from people included, "I have an alarm button that works and I can use" and "They have a buzzer in their room and there are security codes on the door, so the building is secure." One person told us they felt safe because, "There are people around me who I can talk to." Records showed staff had undertaken training with regard to safeguarding

vulnerable adults. They were able to describe in good detail how they would deal with any concerns about potential abuse at the home, although all the staff we spoke with told us they had not seen anything to concern them.

At the previous inspection we had found accidents and incidents had been dealt with appropriately. At this inspection we found they continued to be appropriately dealt with at the home. There was a quarterly review of such incidents across all the provider's establishments which looked at any causes or recurring themes in relation to falls or other events.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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.

The registered manager told us there were currently four DoLS granted for people living at the home and a number of other applications were pending. We saw documentation in people's care records that confirmed appropriate legal processes were being followed.

The registered manager told us a significant number of people living at the home were also living with a dementia related condition or some level of cognitive impairment, although she described these as secondary to people's physical needs. We noted in a number of care plans people were described on assessment as having severe cognitive impairment. However, it was not always clear from care records how decisions about the care and support people required were made. For example, in one person's care records we found unsigned consent forms for the taking of photographs and the sharing of information with outside professionals, although the forms had been signed by the registered manager. The individual's care records stated the person was living with an advanced cognitive impairment. We could find no indication a best interests decision had been taken in relation to the two issues. We also found that where relatives had Lasting Power of Attorney (LPA), they had not signed consent forms to confirm they were in agreement with actions the home may take.

We also found people's ability to consent had not been reviewed. One person's care records stated they had given verbal consent to share information in February 2016 and their care plan stated they were able to make simple decisions. An assessment dated November 2016 stated the person, "never makes simple decisions." We spoke with the nurse on duty about the person's capacity, who told us the individual did not have capacity to make decisions because they were "usually disorientated." There was no indication in the person's file that consent had been reviewed or best interests decisions had been made. This meant we could not be sure people's rights were protected because there was limited evidence of appropriate consent being sought and reviewed and limited evidence of best interests decisions being undertaken.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 11. Need for consent.

Staff talked knowledgably about obtaining day to day consent. They said they took time to explain actions to people and continue to explain what they were doing during personal care, to ensure they were happy

with their approach. They told us they knew people well and so could tell from people's reactions or facial expressions if they were unhappy or distressed. They were not always clear about best interests decision processes. The manager forwarded us a copy of the home's most up to date training record. We noted training on the MCA / DoLS was not listed as part of the provider's mandatory training. The provider subsequently sent us a revised training record stating the MCA / DoLs training had been omitted from the original documentation provided.

Staff told us they had access to a range of training. Comments from staff included, "We get enough training; I think we do really well. We have a full weeks training before we start" and "You can never have too much training." The senior manager told us the provider had their own training facility which was used for staff from all the provider's homes. The registered manager demonstrated the electronic training system. She showed how available courses were accessed on the electronic system and how these could be booked by staff. When staff booked courses, this information was transferred onto the home's duty rota, to ensure they were not put on shift that day. The home also had a training matrix linked to the system. The matrix showed when staff had completed courses and highlighted training was in need of updating. We saw the majority of staff had completed recent updates of mandatory training including training on fire safety, moving and handling, dementia care and palliative care.

Staff also confirmed they had access to a range of supervision sessions and an annual appraisal. The registered manager told us they had recently changed the way supervisions were conducted and they had removed the list of set questions and now only recorded significant information. We looked at recent supervisions records and saw a range of issues were discussed, including any personal matters that may be affecting people's work. The registered manager said she had just sent out pre-appraisal questionnaires for staff to complete and had also completed a small number of meetings with staff. We saw evidence of appraisal meetings and noted completed documents were signed by the registered manager and the staff member.

People's health and welling were supported. On the first day of the inspection one person was being supported to attend a dental appointment at a local surgery. There was evidence in people's files of visits to local hospital or outpatient appointments. There were also documented records of visits to the home by health professionals, such as general practitioners or specialist nurses. One person told us they had access to a range of professionals. They told us, "I have access to all of these people. I saw a physiotherapist this morning. If I was unwell I would go to the nurse and she would help. I can go to anyone." A relative told us, "Anything clinically wrong they deal with it or call the doctor."

The registered manager and senior manager told us a range of meal choices were available at the home. On the second day of the inspection we witnessed a member of the kitchen staff approaching people and asking them which of two meals they would like that day. The senior manager told us if people wanted something specific they could go to local shops to source it. People we spoke with told us they were not always aware of this. The majority of people told us they enjoyed the food. We asked people if they had enjoyed lunch on the first day. Comments included, "I have enjoyed my lunch, the food here is very nice" and "One thing we can't complain about is the food. We always get plenty and always what we ask for." One person told us, "I don't enjoy the food, although the variety is good." They said they often went shopping and bought items they fancied which the chef prepared for them.

We spent time observing meal times on both days of the inspection. On the first day, because of limited staff availability in the dining room some people were not well supported. However, on the second day of the inspection meal times were better organised. People's care files contained an assessment of their nutritional needs and their weights were regularly monitored. The registered manager told us only a limited

number of people had their dietary intake monitored through the use of a food and fluid chart. We found these charts were not always well completed. There was no clear target for the amount of fluids people should be receiving during the day and daily totals were not updated or checked. One person's records suggested they had only received 200 mls of fluid on one day. The registered manager said she would review whether people required monitoring through the use of food and fluid charts.

A number of people at the home were living with a dementia related condition. We saw the physical environment was not conducive to dementia care. Areas such as toilets and bathrooms did not have pictorial signage, which often helps people with a cognitive impairment. Some carpets in the corridors were heavily patterned, which can often be confusing to people living with dementia. There was also a change in carpet colours in corridors, which may look like a step where there is reduced vision or confusion. We also noted the home had a large garden, although this was not fenced, meaning people living with dementia could not explore the garden without direct staff supervision. We also noted menus at the home were not supported with pictorial representation of the food, making choice easier for people who may not immediately recognise written words. We spoke with the registered manager, provider and senior manager about this. They told us they were already looking at fencing some of the garden and said people were supported by staff in the summer. They agreed to look further at the environment as and when refurbishment took place.

We recommend the provider considers National Institute for Health and Care Excellence guidance and other best practice guidance on environments designed to support people living with dementia.

Good

Is the service caring?

Our findings

People and their relatives told us they felt the staff at the home were very caring and were happy with the support they received. Comments from people included, "I am well looked after" and "Yes I am happy here." Relatives told us, "This place meets their needs much better and has a homely feel. Their general physical health is good since they moved here"; "The staff are lovely and take care of them well. Generally the care is okay" and "I have seen nothing but respect and kindness from the staff." One relative told us, "If I have to go into a home I would like to come here; it's lovely and homely."

We spent time observing how people and staff interacted throughout both days of the inspection. We saw staff treated people with patience, kindness and consideration. Although busy, staff took time to chat to people as they went past. Several people enjoyed one staff member telling them about their recent holiday abroad. Even though busy during the lunch period, staff took time to respond to people's requests in a pleasant and open manner. One person told us about an unfortunate issue when woken suddenly in the early morning by an agency staff member to give them some early morning medicines. Whilst they said this had upset them they stated this was unusual and did not happen when regular staff were on duty.

Staff told us there was no one living at the home who had requested support with issues of equality and diversity; such as issues around race, gender, religion or ethnicity. A number of people had indicated they held particular religious beliefs during the assessment, prior to them coming to live at the home. We noted in one person's care file it was noted they had been a regular church goer prior to coming to live at the home. The plan asked staff to make sure this person was able to view any religious services on television. Staff said some people were supported to attend local churches, if they wished.

There was some evidence in people's care records they had been involved in planning their care prior to coming to live at the home. Care records also showed that, where people had capacity, they had been involved in reviewing their care. Comments from people included, "I know about my care plan and this was discussed with me last week" and "I do my care plan with the nurse. We update this regularly; if they don't, I tell them." Relatives told us they felt involved in care decisions and were kept informed. Comments included, "I am fully informed what's going on. If (relative) had a sore toe, I would know about it" and "(Relative) had a urine infection and we were informed about that. If we have any questions staff are always willing to talk to us." Some relatives suggested responses to queries were not always as timely as they could be.

There was evidence of 'residents' and relatives'' meetings taking place at the home. Relatives told us they received advanced notice of the meeting through a poster being placed at the entrance. People told us they could raise issues at the meetings. They said they had asked for a settee to be purchased for the conservatory area. They said, "People can voice their opinions and things do change. We have asked for a settee in the conservatory as it will be more comfortable when relatives visit. We've also asked for another bench in the garden so more people can sit out in the summer, when it's nice, and have afternoon tea. Hopefully this will happen." The senior manager told us some additional benches had already been purchased and more were planned for the spring. Other comments on 'residents'' meetings included, "I

think there is one coming up. If we are not happy with something it can be changed. People say what is on their mind" and "I think we are listened to." One person told us they were aware of the meetings but did not attend.

The manager told us some people did have access to an independent advocate if they felt this was required. On the days of the inspection a number of people were having their care reviewed by outside agencies and we saw they took time to speak with people individually about their care and also consulted with family members, where appropriate.

Staff understood about the need to maintain confidentiality and care records were stored in office areas when not being completed. MARs were kept on top of medicines trolleys, which were in turn stored in a lounge area and on a landing. Although containing limited personal details these records should have been stored securely to help protect private information. We spoke with the registered manager about this who agreed the records should be removed from this area.

People told us staff respected their privacy and dignity. Comments from relatives included, "They do knock on their door before entering" and "They always knock on the door and always ask permission. They say, 'Is it alright (name) if we do this?'" Staff spoke in detail about how they supported people's privacy and dignity, ensuring doors and curtains were closed during the delivery of personal care and ensuring people remained covered as much as possible. People's rooms had small signs on the door indicating they should not be disturbed when staff were supporting people with personal care activities. We saw the home had a candle placed on a small table near the front door. A notice advised visitors that if the candle was lit this indicated someone at the home may be approaching end of life and asked visitors to be respectful during their visit. In one person's room there was a handwritten poster on the wall containing personal details. This was in full view from the corridor. We spoke with the registered manager about this. They said this had been put up by the person's family but agreed it should be moved to a less public part of the room.

The registered manager told us they had close links with the local hospice and palliative care teams. She said they had good support from these organisations and worked closely with them to ensure people had high quality end of life care. People's care records contained end of life care plans with good detail about how people wished to be supported at this stage of their lives.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us the staff were responsive to their needs. Comments included, "I get pain relief when I want it. I asked for some today and it was given to me"; "Because I am independent the staff leave me to myself. If I need help they are always there to assist me" and "I can have a bath as often as I want; the staff do help me."

People living at the home had care plans in place to determine how staff should support them. There was evidence in people's care plans an assessment had taken place prior to people coming to live at the home. This assessment included looking at people's medical history, personal care needs and any risks linked to care, such as an increased risk of falls and capacity to make decisions. There was also some detail of the individual as a person, with some information about their past life, jobs, and family.

Following on from the assessment, specific care plans had been developed. Areas of care support included; moving and handling, personal hygiene, support with continence and nutrition. Risk assessments were linked to these care plans, although these had not always been updated.

Care plans, to allow staff to deliver individual care, covered such areas as mobility and falls risks, personal care support, foot care linked to diabetic conditions and nutrition. The majority of care records contained sufficient information to allow staff to deliver basic care and support. Plans had been subject to a review, although this was not always detailed.

The registered manager told us the home had an activities worker, who spilt their time between Beanlands and another of the provider's homes. The manager told us there was a record of activities at the home, but this was not available during the inspection. People told us they were aware of the activities and could choose whether they participated or not. One person told us, "I have a list of events here in my room." We saw details of events were displayed on the wall. They further commented, "I enjoy these activities." People also told us they had the opportunity to go out if they wished. A relative told us, "We take (relative) down when the singers are here, which they enjoy very much. They do knitting and colouring." One person told us, "I go out on my own, as I like this. Staff would come with me if I wanted them to."

We looked at entries in the activity logs in people's individual care records, particularly for those people who spent time in bed or were living with dementia. We found the entries suggested that one to one time for these people was not fully utilised. Entries included comments such as, 'One to one. Called to see (name). They were fine and settled watching TV'; 'Reading – Activity sheet read and given to (name)' and 'One to one – Called to see (name). I brought her up to date with the day, date and time of year." One staff member told us, "We do not do ourselves any favours sometimes because we do things with people but don't record them as activities. Like, for example, a pampering bath is different from a bath to get clean. Doing nails and hand and foot massages are other things we do that people value but we don't record." We spoke with the registered manager and the provider about ensuring individual activities helped to meet people's needs and were meaningful. The registered manager told us the home was engaged with outside organisations to help involve the community more with the home, particularly in relation to supporting people with dementia.

We recommend the provider reviews activities for people living with dementia to ensure they provide appropriate support and stimulation.

The senior manager told us about changes to the role of care staff at the home to try and improve individual interaction. They told us they were moving away from the term key worker to that of befriender. One of the key tasks of the befriender roles was to ensure they spent ten minutes of quality time with people they were responsible for each time they were on shift. They said they were currently in discussion with care staff about this change. A senior staff member told us, "This is an area where I would agree we need to improve. I have spent a lot of time speaking to staff about this and have changed the keyworker name to help staff to more clearly understand what we want them to do to help people."

The provider had in place a complaints policy and procedure. Information on how to raise a complaint was displayed on notice boards around the home. The registered manager told us there had been only one formal complaint in the last 12 months which had been dealt with by the provider's head office. Some relatives told us they had raised issues but had not always had timely responses. We advised the registered manager of these comments and she said she would consider them in dealing with future complaints. We saw there had been analysis of complaints and concerns across all the provider's locations and emerging themes had been identified as part of this review. These themes included issues such as missing clothing, staff attitudes and issues around dignity and respect. We looked at historical complaints to the home and saw these had been investigated and dealt with appropriately.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in place and our records showed she had been formally registered with the Care Quality Commission (CQC) since December 2015.

During the inspection we found records regarding people's care and safety were not always up to date or well maintained. We also found some records had not been stored appropriately to protect personal information. There were significant issues with records relating to the use of topical medicines at the home. Reviews of risk assessments related to people's care and reviews of care plans were not always undertaken in a timely manner or were conducted effectively. Daily care records were often limited in detail or used wording that was not always appropriate or dignified, describing people as 'aggressive' and 'verbally abusive', when reporting people's confusion. There was limited information in care records to indicate how staff had supported people during these difficult periods. Some safety records had not been signed to confirm they had been completed by a competent person. This meant we could not be sure records were accurately kept and were a true reflection of the running of the home.

The registered manager showed us a range of audits undertaken at the home. However, we found they were not always a true reflection of what we found at this inspection. For example, medicines audits stated that all variable dose medicines had the individually administered doses recorded, which was incorrect. A medicine audit dated 13 January 2017 stated all topical cream charts had been completed, yet we found records had not been updated for a significant number of months. Health and safety audits at the home had failed to identify issues related to missing or inappropriate window restrictors, sharps boxes being left in public places, open storage areas and laundry or the lack of bedrail covers in some rooms. We noted there had been no registered manager walk around checks recorded as taking place since October 2016. The registered manager told us the current process was bring reviewed to determine if it was effective, but that she continued to walk around the home each day. The provider told us the company engaged a range of people to assist with the monitoring and audit process and these items had not been identified by these professionals. This meant audit processes and oversight was not robust and had failed to identify potential risks or concerns within the home.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17. Good governance.

One person told us they had recently been given a questionnaire to complete. They said they were asked questions such as, 'Are you happy with the laundry?' The senior manager told us she took time to regularly complete dignity questionnaires with people. She said she undertook a review with people after they had been at the home two months. However, we noted the last available questionnaires were dated October 2016 and several contained comments such as, 'Because of dementia unable to answer questions.' There was no indication people's families had been approached. Questions on the questionnaire included issues such as whether people felt they were treated as an individual, whether they could maintain their independence and whether they felt respected. We saw one person had raised an issue about staff asking them to retire to bed at a certain time and this matter had been followed up and addressed by the

registered manager.

People and relatives told us they knew the registered manager, by sight if not directly. One person told us, "I don't see her very often, but if I need to talk to her she is always available." People and relatives also told us the provider regularly came to the home and walked around chatting to people and asking them how things were. One relative told us, "On Christmas Eve the owner came to the home and introduced himself and made us feel very welcome." They told us they very much appreciated this gesture and they felt comfortable with the approach. They also commented, "He seems to have a good relationship with the staff."

Staff told us they registered manager was approachable and responded to any issues or concerns they had. Comments from staff included, "You can talk about anything, she is so approachable" and "The manager is fine. I go to her and she sorts things out. I just go and see her if I need her to intervene." They said there were staff meetings at the home and they felt able to raise any issues or concerns.

Staff also told us they enjoyed working at the home and supporting the people who lived there. Comments from staff included, "It's not just about the person in the bed; it's everything. The whole picture"; "We look after them as if it was our family. This is their home and we are invited into their home" and "I enjoy it. I love looking after people. I'm here because I want to be here."

This was the second rating inspection of Beanlands Nursing Home. We noted the previous quality rating was on display within the home and on the provider's website, as legally required. The registered manager had ensured that notifications of significant events at the home, such as deaths and serious injuries, had bee made in a timely manner.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Systems were not in place to ensure care and treatment was provided with the consent of the relevant person or in line with the MCA (2005). Regulation 11(1)(2)(3).

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 Systems were not in place to ensure care was provided in a safe effective manner. Systems to monitor and mitigate risks related to the environment, equipment and medicines were not managed in a safe and effective manner. Regulation 12(1)(2)(a)(b)(d)(e)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes had not been established to assess, monitor and improve the quality and safety of the service or mitigate risks. Records relating to the running of the service and the delivery of care were not always accurate, complete or contemporaneous. Regulation 17(1)(2)(a)(b)(c)(d).