Care Quality Commission

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Beech Court Nursing Home

Inspection report

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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?	Requires Improvement

Summary of findings

Overall summary

This inspection site visit took place on 16 July 2018 and was unannounced. Beech Court Nursing Home is a 'care home' with nursing. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to accommodate up to 26 older people, some living with dementia, who require personal or nursing care. At the time of the inspection there were seven people living there.

The provider is registered with the CQC as an individual and therefore it is not a condition of their registration that they have a registered manager. The registered provider has legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last comprehensive inspection in November 2017 we asked the provider to take action to make improvements to infection control. This action has been completed. We found peoples' rooms and communal areas were clean and there were no lasting odours around the building. Staff followed good hygiene practice.

At the last comprehensive inspection in November 2017 we asked the provider to take action as quality audits were not being used effectively to ensure improvements were made where necessary, such as around infection control. This action had been completed. Audit systems were in place and being effectively implemented. We noted improvements in the quality assurance systems to both monitor and improve the governance of the service.

The provider acknowledged that the service having a registered manager who would have day to day oversight of the home would ensure that these improvements could be sustained as and when occupancy increased. The provider showed a commitment to recruit a registered manager to improve leadership and guidance for staff.

People using the service told us they felt safe living at Beech Court and relatives we spoke with agreed. People were kept safe from avoidable harm because the staff team had received training on safeguarding and understood their responsibilities.

The risks associated with people's care and support had been assessed, monitored and reviewed. People received their medicines as prescribed.

Appropriate pre-employment checks had been carried out on new members of staff to make sure they were safe and suitable to work there. There were sufficient staff to meet people's needs and spend time with them.

New staff were provided with appropriate induction into the service and on-going training was being delivered. This enabled the staff team to gain the skills and knowledge they needed in order to meet people's needs. Staff were also supported through regular meetings with their manager and an annual appraisal.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People who used the service and relatives consistently told us staff were kind, caring, patient and upheld people's dignity. Care plans were personalised and centred on people's preferences, views and experiences as well as their care and support needs.

People and relatives knew how to raise any concerns and were confident these would be dealt with effectively.

People who were receiving end of life care were provided with compassionate and skilled care with appropriate involvement from health professionals as needed.

We have made a recommendation about consulting with current best practice guidance about developing a dementia friendly environment.

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 had improved to Good.

Infection control measures had improved and training for staff updated in this area.

Systems were in place to ensure people were protected from abuse and unsafe practice as staff were knowledgeable and had received training.

People's identified risks were individually assessed and ways to reduce the likelihood of the person being harmed were considered.

Appropriate arrangements were in place for the safe administration and disposal of medicines.

Sufficient numbers of staff were provided to safely and effectively meet people's needs. Staff recruitment procedures and checks promoted people's safety.

The service had learnt and acted to make improvements where necessary.

Is the service effective?

Good

The service remained Good.

People's needs had been assessed and incorporated into care plans.

Staff were provided with a regular programme of training, supervision and appraisal for development and support.

People were supported to eat and drink enough.

People were provided with access to relevant health professionals to support their health needs. Staff knew about people's health needs and personal preferences and gave people

as much choice and control as possible.

Staff had received training and showed an understanding of the Mental Capacity Act 2005.

A recommendation was made about ensuring the premises were improved to ensure it met all people's assessed needs.

Is the service caring?

Good

The service remained Good.

People living at the home, and their relatives, spoke highly of the caring approach of all staff.

Staff respected people's privacy and dignity and knew people's preferences well.

Is the service responsive?

Good

The service improved to Good.

People's care plans contained detailed information about physical, social and emotional needs and these had been reviewed to ensure they were up to date.

People living at the home, or their relatives, were confident in reporting concerns and felt they would be listened to.

People's individual interests were reflected and acted upon to ensure their social needs were met.

People received effective and caring end of life care.

Is the service well-led?

Requires Improvement

The service remained as Requires Improvement.

Quality assurance processes had improved and audits reflected these were effective to ensure the service offered good quality and safe care and treatment.

Consistency in leadership of the service needed to be improved

to sustain the improvements that had been made.

The staff promoted a positive culture that was person centred.

People and relatives' views were sought to continuously improve the service.

The service worked in partnership with relevant bodies to improve where needed.

Care Quality Commission

Beech Court 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 16 July 2018. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was supporting older people with dementia.

Prior to the inspection, we reviewed other information that we held about the service such as notifications. These detail events which happened at the service that the provider is required to tell us about. We did not request that the provider send in a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with four people living there and two relatives. We also spoke with the provider, five members of staff, a chef and a cleaner.

Some people were unable to verbally communicate so we spent time observing care provided in the communal areas to help us understand the experience of people who could not talk with us. By observing the care received, we could determine if they were comfortable with the support they were provided with.

We reviewed a range of records about people's care and how the service was managed. This included four people's plans of care and medicines records. We also looked at associated documents including risk assessments. We looked at records of meetings, recruitment checks carried out for five members of staff and the quality assurance audits the provider had completed.

Good

Is the service safe?

Our findings

At the previous CQC inspection in November 2017 we identified concerns that the provider had not ensured there were effective infection control systems in the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We reviewed this during this inspection and found the provider had made improvements.

We found peoples' rooms and communal areas were clean and there were no lasting odours around the building. We saw rotas in place to ensure deep cleans of hard to reach areas. Cleaning equipment followed good hygiene practice. For example, there were colour coded mops, buckets and cloth. This prevents cross infection between high risk areas such as toilets and lower risk communal areas. The person responsible for cleaning had a good understanding of infection control and control of substances hazardous to health (COSHH) and had received training in these areas. During the day we saw staff following good hygiene practice; washing hands, wearing personal protection equipment and carrying soiled materials in sealed bags.

During our observations of the environment, we brought to the attention of management a piece of equipment in a communal area that could pose a risk to people. We also noted that the cellar door did not have a suitable lock on it to prevent people accidentally accessing this and potentially falling. People in the home were not mobile in that area which reduced these risks. However, the owner sent confirmation the following day with photographic evidence that these two issues were immediately rectified. This removed any potential risk. We saw that the other areas of the premises and equipment had been maintained in line with policy. Records showed equipment and the environment were monitored. These included fire precautions with checks on emergency lighting, emergency evacuation drills and weekly alarm tests. Electrical, gas, water safety had been checked in line with policy to ensure safety. Equipment used for moving people had been maintained and serviced to keep people safe.

Staff had the knowledge to safeguard people and keep them safe. Records showed that staff had received training in safeguarding adults and understood their responsibilities to identify and report any concerns. Staff were confident that action would be taken if they raised any concerns relating to potential abuse. A member of staff said, "We report abuse to the nurse in charge, provider or outside to social services, CQC and safeguarding".

People and their relatives told us they felt safe in the home and that staff were trustworthy and sufficiently skilled to keep them safe. Comments included, "Like living here. Nice and safe. Everything seems to be, well, lovely"; "Safe enough. Carers very good, staff around if anything happens" and "Quite safe here. People [carers] quite good. Help at night if you want it". A relative said, "Been a God send. 100% sure that she couldn't be better cared for".

People had individual risk assessments in respect of their care needs. These included areas such as pressure sores, malnutrition, moving and handling and fire. For example, one person was at risk of developing pressure sores. They had pressure relieving equipment in place and a management plan which guided staff.

These were reviewed monthly and whenever there were changes to risks. People had Personal Emergency Evacuation Plans (PEEPs) to assist emergency services quickly assist evacuate people in the event of a fire.

There were sufficient staff on duty with the required skills to meet people's needs. Staff were not rushed in their duties and had time to sit and chat with people. During our inspection we saw people's requests for support were responded to promptly. It was acknowledged during discussions with the owner that the home was greatly under occupied at the time of this inspection and that monitoring staffing levels when numbers increased was required. The owner agreed that this would be done to ensure people's needs continued to be met when numbers in the home increased. A member of staff said, "We are still coping with staffing with the current number of residents".

We saw a range of pre-employment checks were in place, such as Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals. This helps employers make safer recruiting decisions and employ only suitable people who can work with potentially vulnerable adults.

Medicines were administered safely. There was accurate recording of the administration of medicines. There were no gaps on MAR charts. Topical MARs were maintained. People had comprehensive PRN (as required medicines) protocols in place. The nurses completed effective medicine audits.

The service had taken action following accidents and incidents. For example, bruising was noted on a person. Action was taken to revise the moving and handling by staff and the family were informed in line with the duty of candour. The duty of candour is a legal duty to be open and honest when things go wrong.

Good

Is the service effective?

Our findings

People's needs were not always met by the design and adaptation of the premises. For example, ensuring the environment was suitable for people living with dementia to independently navigate areas of the building. However, the current occupancy level of the home was low and people's high level of needs meant staff were required to fully support people moving around the premises which lessened the impact of the environment. However, when occupancy levels in the home increase and more independent people are supported the provider would need to consider making adaptations to ensure the environment reflects people's needs and promotes their independence and safety. The premises had been extended but the extension was not in use at the time of the inspection.

We recommend the provider consults with current best practice and guidance to develop a dementia friendly environment.

People's needs were assessed before they came to the home. Information was sought from the discharging service, people's relatives and other professionals involved in their care. Care, treatment and support was delivered in line with legislation and evidence-based guidance. For example, the service had a copy of newly published guidance by the International Dysphagia Diet Standardisation Initiative (IDDSI) which described new definitions for texture modified foods and thickened liquids for people with dysphagia (difficulty swallowing).

Staff were supported to complete an induction programme before working on their own. The induction was set specifically for each role. Staff told us they had the training they needed when they started working at the service and were supported to refresh their mandatory training. Staff completed training which included safeguarding, infection control, manual handling and fire safety. During the day we observed staff supporting people with moving and re-positioning. Staff followed good practice guidelines, ensuring that people who needed hoisting had their personal sling, explaining what was happening and offering reassurance throughout.

Staff told us they were supported through supervisions. Records showed staff had received supervisions as well as appraisals. A member of staff said, "I feel supported and receive supervisions regularly".

People were supported to eat and drink enough. People said that they liked the food and they were given choices, food that they enjoyed eating which was cooked well. Comments included, "Food is sort of like home cooking, good variety, very nice meat, comes from a local butcher"; "Nice dinner today. Totally enjoyed the shepherd's pie" and "Plenty to eat". We saw that alternatives were available if people wanted something different. Throughout the day we saw that people had access to drinks with staff offering hot and cold drinks. People had plenty of drinks in their room and communal areas were well supplied with drinks. Food and snacks were available throughout the night. People's weight and hydration were maintained.

People's had access to care, support and treatment in a timely way with referrals made to appropriate social and health services when people's needs changed. We saw records of visits and letters from healthcare

professionals in people's care files, such as speech and language therapists (SALT), chiropodists, opticians and dentists. We saw SALT had assessed a person with swallowing problems and guidance was in place regarding food texture and thickening levels for fluids. All this information was on the person's care plans and in the kitchen. People had access to their GP if needed. A person told us, "GP comes in if I need to see one. Comes in regularly to check on others". A relative said, "The slightest thing and they will call in the GP and let me know straight away".

Staff had been trained and understood the requirements of the Mental Capacity Act 2005 (MCA). The 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. We observed staff asking permission before carrying out any care tasks and people were given the opportunity to make their own decisions and choices. For example, staff knew that a person living with advanced dementia had the capacity to respond to staff. A member of staff told us that the person could respond by nodding, moving her head from side to side or shouting a firm negative response. We observed staff acting on these responses. A relative told us, "She can communicate her wishes strongly".

Records showed people were supported in line with the principles of the MCA. Where required, mental capacity assessments had been completed and best interest process followed. A member of staff told us, "We always assume [people] have capacity". Another staff member said, "If any decision is made on someone's behalf, it has to be in that person's best interest".

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any DoLS applications had been made to the local authority. We saw these had been appropriately applied for as required and for those still waiting to be authorised they were monitored to ensure people were supported in the least restrictive way.

Good

Is the service caring?

Our findings

We observed and heard that people were treated in a kind and positive manner and there was a warm and friendly atmosphere. People commented, "See the same carers. All very good"; "People [care staff] nice and kind to me. Look after me very well" and "Very good carers really, don't think they would keep them if they weren't". We saw one person receiving palliative care from staff that were very attentive and demonstrating empathy whilst supporting them. Staff were vigilant and were always present in the communal area to supervise and tend to peoples' needs. For example, a person was helped to stand and taken to sit by a window because she liked to watch the birds feed.

Staff had developed good relationships with people and we saw warm interactions between staff and people. Staff spoke respectfully to people and knew the people they supported well. Staff recognised when people needed emotional support. We observed a person receive emotional support from a member of staff who recognised that they were becoming upset. The staff member sat with them, holding their hand and talking to them in a kind, reassuring way. The person's body language indicated that it had made a real difference to their wellbeing. On another occasion we observed a member of staff sitting with, and calming a person, who was becoming anxious. All the relatives we spoke with were positive when asked if they felt their family members were cared for and happy. Comments included, "She gets lots of attention. Very kind to her and they [staff] take time to explain to her what is going on"; "Staff very good, kind and helpful" and "Carers very nice always tell me what she has been like".

The staff team had the information they needed to provide individualised care and support because they had access to people's plans of care. These included details about people's past history, their personal preferences and their likes and dislikes. A member of staff said, "We have an EDHR policy in place. We embrace diversity and treat people as I would like to be treated".

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS. We saw that staff sought accessible ways to communicate with people. We saw that people's communication needs was recorded in their care plans providing information and guidance on how best to communicate with people who had limitations to their communication. For example, whether the person had hearing or sight difficulties. We saw staff communicating with a person who had difficulty expressing themselves verbally. Staff spoke to the person slowly, listened and observed for facial expressions. This meant peoples' opportunity to communicate effectively had been considered by the service.

People's independence was promoted. Staff told us that people were encouraged to be as independent as possible. A member of staff said, "We promote independence by encouraging people to eat with little support".

People were supported to express their views and were involved in making decisions which were respected. During the day we saw that people were making a variety of choices. People were choosing what drinks they

wanted, where they sat, where they wanted to go and what they wanted to do in the way of activities. People's spiritual needs were met. We saw a member of staff sitting with a person reading sections of the bible to them. The relative said, "Very nice to do that for her". Relatives told us they were involved with and informed about their family member's care planning. One said, "Have us in once a week to talk through her plan and let us know what is happening. Phone us as soon as anything happens".

We saw and were told that peoples' privacy and dignity was respected. We saw staff knocking on people's doors before entering and closing them before delivering care. A member of staff said, "We always knock before we go in. We close curtains and doors during personal care". People's rooms were personally decorated in colours they had chosen and they had photographs and items displayed that were important to them. This also showed people were treated respectfully.

Staff understood and respected confidentiality. A member of staff said, "We do not talk about residents to anyone even people we work with unless they need to know". We saw that records containing people's personal information were kept secure. Where information was stored on a computer, the service complied with the Data Protection Act.

Good

Is the service responsive?

Our findings

People had care plans in place that were based on assessments of their needs. Care plans seen covered needs such as personal care, communication needs, eating and drinking, emotional well-being and medicines. People's needs were reviewed regularly to ensure their care and support was up to date. People's care records contained detailed information about their health and social care needs. Care plans reflected how each person wished to receive their care and support. We saw daily records were maintained to monitor people's progress on each shift.

All staff we spoke with knew the needs of each person well and could tell us what people had done before coming to the home, specific needs, likes, dislikes and how they liked to be approached. For example, a member of staff told us about a person who enjoyed classical opera and how they sang to her and with her. We heard classical music being played in the lounge and was told that she liked hearing it. Staff also told us how a person had helped to build a local shop as an apprentice and how they had taken him to see it. Relatives we spoke with were confident in the service offering quality care. One commented, "I would unequivocally recommend the Beeches".

People's interests, both past and present, were valued, respected and supported by staff. A programme of activities was organised and led by staff, mainly on an individual basis. We saw activities such as quizzes, board games, crosswords and puzzles provided. There were photographs around the home which showed people taking part in activities. We asked people what they did to keep occupied. One person said, "Have been out in my wheelchair. The carer takes me out". Another said, "Do what I want to do now, watch the birds".

People's individual interests had been acknowledged. We saw that a member of staff had found some Royal Navy photography books for someone that had an interest in this area. We saw the staff member spending time with the person, looking at the photos and talking to the person about them.

We saw the complaints procedure clearly displayed in the home and people and their relatives knew how to make a complaint or raise concerns. No people we spoke with had made any complaints and records showed none had been received since the last inspection. A relative said, "If there is anything I talk to the nurse for anything medical, the administrator for anything to do with the office or for more heavy-duty things the owner".

We reviewed people's experience when they were approaching the end of their lives. Staff caring for people reaching the end of their lives, had access to support and training about end of life care and said how helpful this was. We were told that staff could call on the expertise of a local hospice, GP and district nurses to provide support and advice where more complex end of life care was required. A member of staff said, "During end of life care we make sure we keep people comfortable and maintain dignity". Some people had 'do not attempt resuscitation forms in place and advanced care plans highlighting their wishes in the event of death. For example, one person had expressed their wish to remain and be cared for in the home. A relative told us, 'Have discussed end of life care. All in place".

Requires Improvement

Is the service well-led?

Our findings

At the previous CQC inspection in November 2017 we identified concerns that the provider had not extended the quality assurance systems to ensure all the requirements in relation to the regulated activities were met. This meant not all records were accurate, for example, an audit to monitor infection control. This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. During this inspection we found the provider had made improvements.

Following the last inspection, the provider and managers had taken action to improve the areas of concern around effective infection control and ensuring auditing improved. Audit systems were in place and being effectively implemented. We noted improvements in the quality assurance systems to both monitor and improve the quality and safety of the service. We saw audits had been undertaken on areas such as people's support plans, risk assessments, daily notes, health documentation and medicines. A member of staff said, "Since the last inspection the provider has been more involved with improvement in activities and infection control". Another member of staff said, "Our audits have been more effective in picking up minor concerns".

Beech Court does not have a registered manager in place. The provider is registered with the CQC as an individual and therefore has legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection, the provider was assisted by two managers, who were not registered with the CQC. One was involved with the administrative side of the service and the other manager was mainly involved with the clinical running of the service. At this inspection, we found that these two managers had stepped down from these roles and returned to become clinical leads. This meant there was not consistent leadership in place and not all staff were clear about their responsibilities. This meant day to day management of the service was not clearly defined. We had comments from staff that leadership needed to be improved. One staff member said, "We do not have proactive planning under provider's leadership. We do not have a clear plan to develop". However, it was acknowledged that the provider cared about the service. A member of staff said, "Provider is passionate about this home". We asked the provider what plans they had to ensure there was efficient and sustainable management of the service. The provider assured us that they were attempting to recruit a suitable person to become a registered manager which would allow them to step back and hand over the day to day management to ensure the improvements that had been made in the service would be sustained in the longer term.

Staff demonstrated positive values which was reflected in the feedback we received. We observed staff on the day of the inspection and noted that the staff team worked collaboratively. Staff supported each other, instinctively or when asked and were friendly towards each other and there was a positive atmosphere. A member of staff said, "We have a very good staff team".

People and their relatives told us that they felt involved and their opinions and ideas had been asked for and they had completed questionnaires. One relative said, "Never been concerned that we weren't fully involved".

Systems for sharing information within the staff team were effective. A member of staff said, "We share information through daily handovers". There were regular staff meetings. We saw records of a recent meeting where new guidance for a thickener were discussed and a recent health update on one of the people whose needs had changed.

The provider had worked alongside the local authority and the local Health Watch scheme to make the required improvements. The provider evidenced they were continuing to forge links with the local community and showed a commitment to continue to strengthen these to benefit people in the home. For example, links had been established with a local school and pupils had an opportunity to do work experience at Beech Court. The service had made the relevant submission of notifications to the CQC.

The service had taken measures to learn and act upon findings from previous inspections and had made significant improvements which meant the overall rating of the service was now good. However, at the time of this inspection the occupancy of the home was very low and feedback we received from staff was that a clear management structure was needed to both maintain a consistent level of quality as occupancy levels increased and continue to improve the service. This would mean that each staff member had a defined role and responsibilities to ensure the service was achieving high quality and effective care on a continuous basis.