Mrs Rose Metcalfe

Beechwood House Rest Home

Inspection report

3 Beechey Road
Bournemouth
Dorset
BH8 8LJ

Tel: 01202551305

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

An unannounced inspection tool place on the 29 November 2016 and was carried out by a single inspector.

Beechwood House is a residential care home for older people. The service is registered to provide care for up to 13 people and was fully occupied. Each person had their own bedroom and with the exception of one have en-suite toilet and wash hand basin. A lift provided access to the first floor. There is a specialist bathroom, a lounge and communal dining room and on site laundry and kitchen facilities.

There is 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.

Statutory notifications had not been made to CQC which meant that we had not received information to support our monitoring of the service. Audits were being completed in most areas but did not include care and support plans or identify that medicines were not being administered in line with best practice. This was an area that the registered manager was aware of and at the time of our inspection an audit schedule was being implemented. People had provided feedback about the service in a quality assurance survey in October 2015. Any issues raised had been addressed in a timely and appropriate way. Feedback has been extended in the next survey to include staff and people's relatives. A complaints procedure was in place and people felt if they needed to use it they would be listened to and actions taken to put things right.

People's medicine was not stored and administered in line with best practice guidance which increased the risk of people not receiving their medicines correctly. Staff had been trained to safely administer medicine and had their competencies regularly checked. People received their medicine as prescribed and staff were aware of how to report an error.

People were supported by staff who had received training in how to recognise abuse and the actions they would need to take if they felt a person was at risk. Staff had been recruited safely which included checks with the disclosure and baring service to ensure they were suitable to work with vulnerable people. There were enough staff with the right skill mix to meet people's needs. Staff received regular supervision and were supported to carry out their roles effectively.

Risks to people were assessed and staff understood their role in minimising risk whilst ensuring people's choices and freedoms were respected. Personal evacuation plans were in place to ensure people would receive the support they needed in an emergency.

People were involved in decisions about their care. When they were unable to do this the principles of the mental capacity act were being followed. Where people had a power of attorney staff understood the scope of decisions they could make for a person.

Staff understood people's dietary needs including allergies and special diets. Food was freshly cooked and available at any time of the day. Specialist crockery, beakers and plate guards were used to support people to enjoy their meals independently.

People had access to a range of health care which included chiropodists, opticians, GP's and community nurses.

Staff were caring and had warm friendly relationships with the people they supported. Staff attitudes were positive and they were described as respectful, open and friendly. People's communication needs were understood by staff and included appropriate use of body language. This enabled people to be involved in decisions about their day. Staff had a good understanding of people's interests, likes and dislikes which meant they could have meaningful conversations with people. People's dignity and privacy was respected and staff encouraged and supported people to be as independent as possible.

People had been involved in assessments of their care needs prior to moving to the service. Staff understood people's care needs and how they liked to be supported. Daily records were completed by staff that reflected the care and support plan and provided information for when care and support plans were reviewed.

People had opportunities to maintain links with family, friends and the community. Activities were organised within the home and the wider community which were linked to people's interests.

The service had an open, friendly atmosphere and staff were positive about the organisation, their roles and the teamwork. Staff felt informed and appreciated and described communication as good.

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 always safe.

Medicine was not stored and administered in line with best practice guidance.

People were supported by staff who knew how to recognise signs of abuse and the actions they needed to take if abuse was suspected.

Staff understood the risks people lived with and their role in minimising risk whilst respecting people's choices and freedoms.

People were supported by enough staff to meet their needs and they had been recruited safely.

Is the service effective?

Good

The service was effective.

Staff received an induction and ongoing training that enabled them to carry out their roles effectively.

People are supported to make choices in line with the principles of the Mental Capacity Act.

People were supported by staff who understood their eating and drinking requirements.

People had timely and appropriate access to healthcare.

Is the service caring?

Good

The service was caring.

Staff had a good knowledge of people, their families and important events in their lives.

Staff attitudes were positive and they were described as respectful, open and friendly.

People were being offered choices and being involved in

decisions about their care.

People had their dignity and privacy respected. Staff supported people to maintain a level of independence.

Is the service responsive?

Good

The service was responsive.

Staff understood peoples care needs and how they liked to be supported.

Care plans and risk assessments were reviewed monthly and changes shared with staff.

Activities took place both in the service and the community and reflected people's interests.

A complaints procedure was in place. People felt listened to and their concerns acted upon.

Is the service well-led?

Requires Improvement

The service was not always well led.

Statutory notifications had not been sent to CQC which meant that we had not received information to support our monitoring of the service.

Audits are in place but not fully capturing details of all areas of service delivery.

Quality assurance survey in place which gathered feedback from people and was used to improve outcomes for them.

Staff are positive about the service, feel appreciated and understand their roles and responsibilities.

Beechwood House Rest Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 29 November 2016 and was unannounced. The inspection was carried out by a single inspector.

Before the inspection we looked at notifications we had received about the service and we spoke with social care commissioners to get information on their experience of the service. We also looked at information on their 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.

During our inspection we spoke with three people who used the service and one relative. We spoke with the registered manager, four care workers and the cook. We also spoke with a social worker and community district nurse who had experience of the service. We reviewed six people's care files and discussed with them and care workers their accuracy. We checked three staff files, care and medication records, management audits, health and safety records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

Requires Improvement

Is the service safe?

Our findings

People's medicine was not stored and administered in line with best practice guidance. Some medicine needed to be stored in a fridge. It was stored in a separate locked box in the main kitchen fridge. To ensure the safest storage a lockable fridge solely for medicine storage is recommended. Staff explained the procedure for administering medicine to people. They told us that from the medicine trolley people's medicine is placed into individual pots with the person's initials on the lid. They then put the pots onto a tray and take them to people in their rooms or in communal areas. Once administered the staff member returned to the medicines cupboard to complete the medicine administration records. This procedure placed people at a higher risk of not receiving their medicines correctly. This is secondary dispensing and it can lead to accidental mix-ups and errors. Medicines must be given from the container they are supplied in. We discussed this with the registered manager who told us they would review medicine practice immediately in line with national guidance.

Staff had completed training on the safe administration of medicines and had their competencies checked as part of their supervision. However this had not highlighted that the procedures were not in line with best practice which would ensure risks to people were minimised. There was guidance for staff on when to administer as required medicine such as pain relief. Staff was aware of the process for reporting errors. We saw that when a recording error had occurred it had been reported as an incident and reviewed by the registered manager and appropriate actions taken.

We recommended the service consider guidance in the 'Royal Pharmaceutical Society - Handling Meds in Social Care Settings or similar professional guidance to review the storage and administration of medicines.

People told us they felt safe. We spoke with one person who told us "I feel safe and cosy in my room". Another said "The staff are so kind, I have no concerns". Staff had completed training and understood what types of abuse people could be at risk from, what signs to look for and the actions they needed to take if they suspected abuse. One care worker told us "I've had safeguarding training several times over the years. There's a poster in the staff loo with the contact numbers".

Assessments had been completed that identified risks people experienced. When a risk had been identified actions had been put in place to minimise the risk. People were involved in decisions about how risks they lived with were managed. Risks had been assessed for moving and handling, skin integrity and eating and drinking. We spoke with staff that had a good knowledge of the risks people lived with and their role in reducing risk. Risk assessments were regularly reviewed with people. One person had been identified as being at risk of weight loss. Food and fluid charts had been introduced to monitor how much the person was eating and drinking. We checked the charts and they were being completed by staff. The risk had been reviewed monthly and when it had increased specialist support had been requested. When we spoke with the person they told us staff had talked with them about it and explained it was related to a health issue. They felt supported and had agreed tothe actions being taken. This demonstrated that people were involved in decisions about the risks they were living with.

Accidents and incidents were recorded and then reviewed by the registered manager. When a risk was identified actions had been taken to minimise further incidents. One person had fallen on two occasions in one month when being supported with moving and transferring. We saw that this had led to a review of their moving and transferring plan and changes to how they would be supported in order to reduce the risk.

Environmental risks were regularly reviewed. These included servicing of equipment such as boilers, lifts and fire equipment. People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency.

People were supported by enough staff who had been recruited safely. Relevant checks had been undertaken before people started work. References were obtained and checks were made with the Disclosure and Baring Service to ensure that staff were safe to work with vulnerable adults. People, their relatives, visiting professionals and staff all told us staffing levels met people's needs. One person told us "There's always enough staff even through the night they check on me". A relative said "There are enough staff to support people. They listen and genuinely have time for people".

Good

Is the service effective?

Our findings

People were supported by staff that had completed the training needed to carry out their roles effectively. Training had included first aid, fire safety, infection control and food hygiene. There had also been training specific to people living in the home which included diabetes and dementia awareness. We spoke with a care worker about some mental health awareness training they had undertaken. They told us "I found it really helpful on how to deal with people. Lots of people live very individual lives and want to be very independent. It helped me understand this".

Staff told us they felt supported and had regular supervision which included practice issues and professional development. One care worker said "I have my supervision with the registered manager. It happens every three months". Staff told us about their professional development. Courses being undertaken included diplomas in health and social care and a team leading and management course.

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.

Most people living in the home were able to make decisions about their care and they did so throughout our inspection. One person told us "I have a choice; I do what I like. (Care worker) always says 'I will do it your way'". Staff had received training in the MCA and demonstrated an understanding of the principles. We spoke with a care worker who explained "You need to know people well to know how to deal with them. Sometimes if they don't feel like doing something, eating something, getting up at a certain time, we try to understand how they feel and how they want to live their lives". Best interest decisions had not needed to be taken for people but the registered manager understood the principle that any made would need to be as least restrictive as possible.

We read in files that people had consented to their care and treatment. Files contained copies of power of attorney legal arrangements for people and staff understood the scope of decisions they could make on a persons' behalf.

Deprivation of Liberty Safeguard was in the process of being applied for where a person who needed to live in the home to be cared for safely did not have the mental capacity to consent to this.

People had their dietary needs understood by both care workers and the catering staff. Information had been collected about people's likes and dislikes, allergies and any special dietary requirements. One person told us "The food is always good". Another told us "There's plenty of food and if I fancy something different they have done it". We observed that specialist drinking beakers, plate guards and bowls were being used which supported people's independence.

People had access to healthcare and records showed us this had included opticians, dentists, GP's, district nurses, chiropodists, community mental health team and dieticians. We spoke with a visiting nurse who told us "They are very good at calling us and asking if they're unsure of anything. The girls are very good at following things we ask them to do which is really helpful".

Good

Is the service caring?

Our findings

People, their families and other professionals all described the staff as caring. One person told us "The staff are really encouraging. When I feel low they encourage me. I don't feel rushed when staff help me. (Staff member) leaves you happy; they don't expect any of us to do things that make us unhappy". A relative told us "It's a very friendly environment. Feels a real family home. The way they support and approach people here is very respectful, open and friendly. They're very interested in people as individuals". We spoke with a social worker who said "We know (person) will be cared for as the staff have a good attitude".

Staff were very positive about the contribution they could make to a person's day. We discussed with a care worker a person who chose to spend all their time in their room. The care worker told us "I've just been talking with (person), asking them if they were enjoying what was on TV. I can make (person) laugh as they have been here a long time. I sing to (person). I know the songs they like". This showed that people were supported by staff who communicated with them in a meaningful way.

People had call bells in their rooms if they needed to call for staff to help them. We observed staff popping in and out of rooms throughout the day of our inspection checking whether people needed anything.

We observed a friendly relaxed relationship between people and staff. One person had a limited understanding of the English language. We observed staff using body language, smiles and hugs to communicate with the person. The person was laughing and smiling with staff and indicated to us how fond they were of the staff member. Staff explained to us that the person's family helped whenever anything needed translating. Staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that were important and of interest to them.

Throughout our inspection we observed people being involved in decisions about their day to day lives. One relative told us "A gentleman is coming in with shoes for (relative) to choose – it's doing home shopping without the internet. Having that independence is brilliant".

Interactions between staff and people were respectful and involved the person in decisions. Throughout the inspection we observed staff explaining their actions to people, giving people time and listening to what they had to say. Information about advocacy services were available and the registered manager told us they actively promoted them to people who did not have family or friends able to support them with decisions.

People had their dignity and privacy respected. We observed staff knocking on doors before entering people's rooms and addressing people in a respectful manner. People's clothes and personal space were clean and reflected a person's individuality.

Good

Is the service responsive?

Our findings

People experienced care that was responsive to their needs. Assessments had been completed before a person moved into the service and this information had been used to form their care and support plan. Information about people was stored electronically and accessed by all the care workers. It included risk assessments, care and support plans and daily records. Each person's care and support plan included an overall summary which provided details of how they liked to spend their time and the support staff needed to provide to help them achieve this. In some instances this contained more information than the main records which in some cases was sparse. We discussed this with the registered manager who told us they would review the plans and add any additional information needed. In addition there was a paper emergency care pack that was used for quick reference or when a person was admitted to hospital. It included details of assessed risks, medicines and emergency contact details. These were being kept on a shelf in the dining room which risked compromising a person's right to confidentiality. We discussed this with the registered manager who immediately removed them to a more secure location.

When we spoke with staff they understood peoples care needs and how they liked to be supported. One person told us "I've been going down stairs more. (Care worker) encourages me. Sitting amongst others you feel not so lonely". We spoke with a social worker who regularly visited a person at the service. They told us "I feel the staff are getting to know (person), I feel they understand the emotional support they need. Since living here they have been involved in pet therapy, there have been visiting owls and there's a TV in their room. They've told us they are happy here and that is massive for (the person)". A commissioner told us "I feel confident they are meeting people's needs. They will tell you about residents and that persons needs but it's not always as well documented in care files".

People were supported to maintain links with family, friends and the community. We were told by the registered manager that family and friends are encouraged to stay and share a meal. Care and support plans included details of people that were important to a person and included family, friends and old work colleagues. Activities took place both in the home and in the community and were linked to people's interests. These included musical entertainment, games and quizzes and visits from a local hairdresser. A trip had been organised to the local pantomime. We saw records that detailed the activities people were involved in each day.

Daily records were completed that detailed how people had been supported and spent their time. They included information about a person's physical, emotional and social support and reflected information we read in peoples care records.

Care and support plans were reviewed regularly. People were involved in reviews. We read one review where a person had felt they needed more clinical support than they had been receiving. The review conversation had been recorded and included discussing available options to the person and then the agreed actions had been completed. This demonstrated that people were listened to and involved in decisions about their changing care and support needs.

A complaints procedure was in place and had been shared with people. We looked at the complaints log and there were no recorded complaints. We spoke with a person who told us "If I had a complaint I feel staff would put it right".

Requires Improvement

Is the service well-led?

Our findings

Statutory notifications had not been made to CQC appropriately. A statutory notification is a legal requirement for the provider to inform CQC of certain situations as part of their oversight of care provision. Notifications had not been received to notify us of people who had died whilst living at the service. We spoke with the registered manager who told us they had been posted to CQC. They showed us a notebook with dates the notifications had been posted. No copies of the forms had been retained at the service. The service had needed to replace gas boilers which led to an interruption of the gas supply affecting heating and hot water. Alternative arrangements had been put in place but as this event had lasted for more than 24 hours a notification should have been submitted to CQC. This meant that CQC had not received information to support their monitoring of the service. We discussed this with the registered manager who told us they would review the regulations as a matter of urgency in relation to statutory notifications.

Audits were being carried out in most areas of service delivery but did not include care and support plans. This was an area that the registered manager was aware of and at the time of our inspection an audit schedule was being produced. Audits that were being completed included medicine administration, staff files and health and safety checks such as bath water temperatures, bed rail and wheelchair checks. The meds administration audit had not been effective in recognising the procedure was not in line with current best practice. We saw that when issues were identified actions had been taken in a timely way. This had included replacing equipment and reporting issues to the registered manager.

A quality assurance survey had been completed by people using the service in October 2015. One person had raised an issue and we saw that the registered manager had met with them. The meeting had led to a more in-depth understanding of the concern raised and had led to changes in their care and support plan. This demonstrated that people's views were listened to and actioned leading to improved outcomes for people. The registered manager told us that a survey was due to be completed again and it would include staff and relatives.

During our inspection we observed open, relaxed and professional relationships between staff and the registered manager. Staff spoke positively about the service, their roles and the teamwork and most of the staff told us they had worked at the service for many years. One care worker told us "I feel appreciated and love working here".

Staff felt they were kept informed. One care worker said "I feel the home is well organised. Handover and the handover book mean that communication is always good". A community nurse told us "Good communication, it's one of the better homes. It keeps their staff which really helps".