Cheerhealth (Bedhampton) Limited

Bedhampton Nursing Home & Specialist Care Unit

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?	Good

Summary of findings

Overall summary

The inspection took place on 23 and 24 November 2016. It was unannounced.

Bedhampton Nursing Home and Specialist Care Unit is registered to accommodate up to 49 people. It provides personal and nursing care services for older people and younger adults who may have a sensory impairment or physical disability. At the time of our inspection there were 37 people living at the home. They were accommodated in private rooms on two floors. Shared facilities included a wet room, hairdresser, two treatment rooms, a quiet lounge on each floor, a conservatory / dining area, and an enclosed courtyard garden.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are "registered persons". Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had put arrangements in place to protect people from risks to their safety and welfare, including the risks of avoidable harm and abuse. Staffing levels were sufficient to support people safely. Recruitment processes were in place to make sure the provider only employed workers who were suitable to work in a care setting. There were arrangements in place to store medicines safely and securely, and to administer them safely in accordance with people's preferences.

Staff received training and supervision to maintain and develop their skills and knowledge to support people according to their needs. Staff were aware of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff supported people to eat and drink enough to maintain their health and welfare. People could access external healthcare services, such as GPs and hospital out-patient appointments.

Staff had developed caring relationships with people they supported. People were encouraged to take part in decisions about their care and support and their views were listened to. Staff respected people's independence, privacy, and dignity.

Staff delivered care and treatment which were based on assessments and plans which took into account people's abilities, needs and preferences. Staff supported people to take part in leisure activities which reflected their interests. People were kept aware of the provider's complaints procedure, but there were few complaints made.

The home had a welcoming atmosphere. People appreciated the honesty and responsiveness of the management. Systems were in place to make sure the service was managed efficiently and to monitor and assess the quality of service provided. The provider responded to feedback to improve and expand the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected against risks to their safety and wellbeing, including the risks of abuse and avoidable harm.

The provider employed sufficient staff and carried out recruitment checks to make sure workers were suitable to work in a care setting.

Processes were in place to make sure medicines were administered and stored safely.

Is the service effective?

Good

The service was effective.

Staff were supported by training and supervision to care for people according to their needs

Staff were aware of the legal requirements where people lacked capacity to make decisions. People were asked for their consent to care and treatment.

People were supported to maintain a healthy diet and were able to access external healthcare services when required.

Is the service caring?

Good

The service was caring.

People had developed caring relationships with staff.

People were able to participate in decisions about their care and treatment.

People's independence, privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

People's care and treatment met their needs and took account of their preferences.

There was a complaints procedure in place, and people were aware of it, but they made few complaints.

Is the service well-led?

Good

The service was well led.

Management systems and processes to monitor and assess the quality of service provided were in place. The provider responded to feedback to improve the service.

There was an open, welcoming culture in which people were treated as individuals and felt able to take part in decisions about their care and treatment.

Bedhampton Nursing Home & Specialist Care Unit

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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on 23 and 24 November 2016 and was unannounced. The inspection team consisted of an inspector 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. On this inspection the expert by experience had both professional and family experience of caring for people who use services.

Before the inspection we reviewed information we had about the service, including previous inspection reports and notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with eight people who lived at the home and four visitors. We observed care and support people received in the shared area of the home.

We spoke with the registered manager and registered provider, an administrator, a nurse, three care workers and an activities coordinator. We spoke more briefly with other members of staff about specific aspects of people's care. We spoke with a visiting community healthcare professional.

We looked at the care plans and associated records of five people. We reviewed other records, including the

provider's policies and procedures, internal checks and audits, quality assurance survey returns and reports, unsolicited feedback from people's relations, training and supervision records, medicine administration records, mental capacity assessments, and recruitment records for four staff members.

Good

Is the service safe?

Our findings

People told us they felt safe and comfortable at the home. One person said, "I feel safe and sure … because of the staff, they know what they are doing." Another person said, "We all feel safe and settled and very happy." A third person told us, "I like living here. It is good."

The provider took steps to protect people from the risk of avoidable harm and abuse. Staff were aware of the types of abuse, the signs and indications of abuse, and how to report them if they had any concerns. None of the staff we spoke with had seen anything which caused them concern, but they were confident any concerns would be handled promptly and effectively by the registered manager. All staff were up to date with the provider's training in safeguarding people. A nurse described the training in this area as "more than adequate".

The provider had made fact sheets available to staff on the subject of safeguarding people and related subjects such as consent and mental capacity. Staff also had a safeguarding and safety handbook. The employee handbook contained information about safeguarding including definitions of abuse and staff members' responsibility to report safeguarding. Suitable procedures and policies were in place for staff to follow.

The provider identified and assessed risks to people's safety and wellbeing. These included risks associated with moving about the home, behaviours that challenge and risks arising from hot drinks. Risk assessments were individual to each person. They identified the hazard, controls in place, and further actions to manage the risk. Assessments were updated when these actions were complete. Staff reviewed risk assessments monthly.

Staff were aware of risks associated with people's care and treatment. We saw staff supporting people to move about the home and change position in a safe way, and using equipment appropriately. Where people's behaviours or communication were at risk of being seen as challenging, appropriate records were maintained to analyse and learn from the behaviours.

Staff used standard tools and methods to assess people's risks of poor skin health and poor nutrition monthly. People had their weight monitored monthly. There were monthly assessments of people's abilities with respect to a standard set of activities of daily living. Systems were in place to identify changes in people's risk assessments.

The provider had procedures in place to keep people safe in an emergency and reduce risks to their health. Staff received training in fire safety and first aid. There were personal emergency evacuation plans in place which showed how people should be supported in the event they needed to leave the home in an emergency. Equipment used in people's care and support was inspected and maintained regularly.

The provider had identified and assessed general risks to the safety and welfare of people using the service and staff. These included risks associated with hot weather, medical sharps and the use of oxygen. There

was a process in place to make sure accidents and incidents were logged, reported and followed up.

There were sufficient numbers of suitable staff to support people and keep them safe. People were satisfied there were enough staff. One person said, "There are always enough staff and they always have time to answer questions and have a chat." Staff told us their workload was manageable. The provider reviewed staff hours every month, taking into account people's dependency assessments and the average numbers of care hours per person. They compared this with an independently produced guidance report on safe staffing levels in nursing homes.

We saw staff were able to carry out their duties in a calm, professional manner. They had time to engage with and chat with people, and if more than one care worker was needed to support a person, they did not have to wait for the right number of staff to be available.

The provider carried out the necessary checks before staff started work. Staff files contained evidence of proof of identity, a criminal record check, employment history, and good conduct in previous employment. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working with people.

People were satisfied their medicines were handled safely, and that they received them at the right time and in a way that reflected their wishes. One person said, "They always tell me what tablets I am taking."

Medicines, including controlled drugs and medicines which needed to be kept refrigerated, were stored and handled safely and securely. Processes were in place for checking in medicines from the pharmacy and destroying medicines which were no longer required. Tablets and capsules were administered from blister packs. Medicines in other containers such as bottles and eye drops were clearly marked with the person's name and the date the container had been opened.

People's medicine administration records were accurate and up to date. Where people were prescribed medicines to take "as required" there were specific instructions for staff. Where people had over the counter remedies which had not been prescribed, the provider had contacted their GP to check they were safe to administer alongside the person's prescribed medicines. There were weekly internal audits of medicines management.

Good

Is the service effective?

Our findings

People living at the home and their visitors were confident staff had the skills and knowledge to support them according to their needs. One person told us, "The staff know what they are doing and if there is an issue, they get it sorted." Another person said, "All the staff are good, nice and helpful."

Staff were satisfied they received appropriate and timely training and had regular supervision meetings two or three times a year. Supervisions included a discussion of issues, concerns, actions, with comments by both parties. Staff had annual appraisals which covered their feedback about their role, areas for better job satisfaction, training needs, targets, and self-assessments in their timekeeping, work relationships and absence record. Staff were able to raise concerns or ideas informally, and one staff member said there was sometimes a "steady stream" of staff talking to the registered manager.

The registered manager had an effective system for monitoring staff training. Their records showed clearly where staff had completed training, where it was due and where it was overdue. There were audits of training files twice a year. Training was followed up by questionnaires covering subjects such as safeguarding, health and safety, first aid, and infection control. These were supplemented by competency booklets for staff to complete in areas such as moving and repositioning. These processes allowed the provider to check that training was effective.

Training was delivered by a combination of methods, including in-house and external courses, and offerings provided by the local council. Additional fact sheets were available for staff on subjects such as diabetes and falls prevention. Staff were encouraged to obtain appropriate qualifications, and induction training was based on the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

The Mental Capacity Act 2005 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 the least restrictive 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 Mental Capacity Act 2015. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. We checked whether the service was working within the principles of the Act.

The provider had suitable procedures in place for assessing people's capacity to make decisions. Records of assessments were in line with the principles of the Mental Capacity Act 2005 and its associated code of practice. Staff were aware of and informed about their legal responsibilities if people lacked capacity. The provider had given all staff members a convenient card with the principles of the Act and a fact sheet about

consent.

Nobody living at the home at the time of our inspection lacked capacity. This meant that the Deprivation of Liberty Safeguards did not apply. The registered manager had applied for authorisation under the Safeguards in the past and had notified us of the fact.

Staff knew about the need to obtain consent, and described to us how they did this and how they reacted if a person declined care for any reason. There were records in place to show people consented to their care plans, and other areas, such as information sharing and use of photographs. Daily care records showed that people consented to their daily care. People's capacity to consent was included in their monthly review of care.

Staff supported people to eat and drink enough. People told us they liked their meals, that the food was appetising and well presented, and there was "plenty of choice". One person said, "The cook is good at balancing what we need with what we like." Staff made sure people had drinks available. A person who was nursed in their room showed us their water bottle and drinking tube. They said, "[Staff] always make sure I have fresh water and it is accessible."

Information was available to kitchen staff about people's individual requirements and preferences, such as allergies and if people needed their food pureed. Where people were supported to eat and drink, this was done sensitively and discretely. Equipment, such as plate guards, was available to help people keep their independence.

Staff checked people enjoyed their meals and were eating enough. They offered different choices if people did not like what they had been served. If people were identified as being at risk of poor nutrition they were offered supplementary drinks.

People were supported to access external healthcare services to maintain their good health. People had routine appointments with their GP, dentist and optician, specialist consultations, for instance with a speech and language therapist, and out-patient appointments for individual medical conditions. Where external healthcare providers gave advice or guidance, this was included in people's care plans.

Good

Is the service caring?

Our findings

There were caring relationships between people and their care workers and nurses. We asked one person what was the best thing about living in the home, and they replied, "The staff. They are caring." Another person said, "[Staff] always have time to chat. They always ask what I would like to wear and eat." Other people described staff as lovely, helpful and approachable.

A visiting healthcare professional commented on the relationship between staff and people, saying "They (staff) know the patients." Visitors told us they were always made welcome. One visitor said, "I am able to visit my wife any time I wish and there are never any issues." The service had received thank-you letters and cards which referred to the "kind and sensitive carers" and their "loving care, compassion and understanding". Relations of people who used to live at the home, were invited back for "reminiscence teas" to share their memories with staff and their loved one's friends.

We observed staff encouraging and praising people. They explained what they were doing, and asked people to participate in their care, for instance by saying, "Can you stand again for me please?" Staff regularly checked people were comfortable, had enough to drink and were warm enough.

People were offered choices and were able to participate in decisions about their day to day care. A care worker supported a person to the dining room table in their wheelchair. When the care worker returned with the person's meal, the person said they were not comfortable. The care worker offered them the choice of remaining in the dining or returning to their room where they would be more comfortable. The person chose their room. The care worker took them to their room and arranged for another member of staff to bring their lunch. Another person's care plan stated they should be given the choice of a mouth wash or mouth care with an electric toothbrush according to their preference at the time.

Records showed people's care plans were reviewed in cooperation with the person, and if appropriate their family or other representative. People were invited to sign their care plans. If they were not able to sign, there was a note on the care plan to show the plan was discussed with them, and how they indicated their agreement. One person had commented, "[I am] wonderfully looked after. No additional wishes or comments at this time." The provider had produced fact sheets for people to assist them in participating in their care and treatment. These included tips for reducing their risk of falls, and a guide to planning their future care.

Staff were informed about the need to make sure people's dignity and privacy were respected, and gave us examples of how they achieved this during their day to day routine. A thank-you card received by the service referred to how staff maintained a person's "grace and dignity". In order to maintain people's dignity, the provider had made canvass messenger bags for people's personal belongings when they went to hospital.

The provider had produced a staff booklet on dignity which included information about the duty and responsibility to promote people's privacy, dignity, respect and rights, and to take account of people's spiritual needs. A local church group visited the home regularly, and staff were aware of people who liked to

attend their services.

Good

Is the service responsive?

Our findings

People's care and treatment were provided in way that met their needs and took into account their preferences and wishes. One person told us, "I wanted to be more independent so the staff have arranged for me to participate in keeping my room clean." Another person said, "When I ask to go out with my husband they always accommodate me and make sure that I am ready."

People's care plans were individual and detailed. Staff told us the plans contained all the information they needed to support people according to their needs and preferences. The plans contained information of what people could do independently and where and how they needed support. People's aims and the aims of any treatment they received were included.

There were separate plans of care for various activities of daily living including, personal hygiene, mobility, breathing, and communication. In addition there were specific plans for individual conditions and circumstances. These included information about eye care following a cataract operation, information about Huntingdon's disease and other medical conditions, plans for long term catheter care and the use of a feeding tube.

A visiting healthcare professional told us the service called them appropriately, when their skills and knowledge were needed to supplement those of the employed nurses. Staff at the home always had the information about the person they needed. When they made recommendations about the person's ongoing care and treatment, their advice was carried forward into the person's care plans.

The registered manager told us most people's care and treatment was intended to support them to manage their medical conditions, but there had been occasions when people had regained sufficient independence to return home or move to residential care. We saw a thank- you card from a person's family which stated they no longer needed nursing care. During our inspection we spoke with a person who was going home for a few days to see if they could achieve sufficient independence.

People could take part in a variety of activities and entertainments according to their interests and wishes. People's interest in wildlife was supported by wild bird feeders in the enclosed courtyard garden. Individual activities included embroidery, gardening, watering plants, and growing sunflowers from seed. Staff tailored other activities according to people's interests, for example knowing the person was interested in politics, they found a quiz about past prime ministers. One person commented to us that staff made sure the magazines available for people to read were always kept up to date.

Group activities and entertainments included visiting singers, sitting games and exercises, pets, a rock and roll themed party, summer fete and barbecue. Kitchen staff took part in these events by providing appropriate snacks and food. Staff kept records of who took part in different events and activities and their response to them. This allowed them to plan future activities according to what people had enjoyed in the past, and to make sure everybody was involved in group or individual activities.

Everybody we spoke with was aware they could make a complaint and how to do it, although only one person had done so. They had complained about the temperature in the conservatory, and this had been addressed to their satisfaction. Other people said, "If I am not happy, the manager will talk to me," and, "If I complain it is sorted."

The registered manager told us other complaints were about maintenance and furniture in people's rooms. They received more compliments than complaints. Compliments were shared with staff and filed. The manager said this was good for staff morale and they interpreted the feedback as confirming people were happy with the service they received.

Good

Is the service well-led?

Our findings

There was an open, inclusive atmosphere in the home. One person said, "This is a perfect care home." Another person said, "It is not like being in your own home, but if I had to live anywhere else, I would not want it to be anywhere but here." People felt empowered to participate in decisions about their care and treatment. One person said, "I am involved in my care plans and we review them regularly. If I have a problem, I know I can talk to the manager." Another person said, "I get involved with my care plan." A third person told us, "If I have a problem the manager will get it sorted or come up with an acceptable alternative." A visiting relation told us they liked the atmosphere in the home which they described as honest and responsive.

Care staff told us they could go to the registered manager "for anything", and the trained nurses were "easy to talk to". Nurses told us care staff were observant and brought it to their attention when they saw changes in people's conditions or welfare. We observed staff getting on with the job quietly and competently.

The registered manager was supported by a deputy manager who was also a registered nurse. They were also supported by the registered provider and a network of peer managers in the provider's organisation.

The registered manager had a programme of staff meetings for formal communication. These included meetings for all staff, meetings for trained nurses, and for ancillary and kitchen staff. Previous meetings had resulted in changes to the way the service was managed. The provider had responded to a request from care staff and changed the colour of their uniform. They had also followed up a suggestion to have a communication book at the two nurse stations.

There had been meetings for people living at the home in August and October 2016. The minutes of these meetings showed they had been used to remind people of the complaints process. People had confirmed staff always knocked on their doors before entering their rooms. One person had said, there was "dignity at all times".

The registered provider told us they had requested feedback from people in July 2016 and had asked them to rate the service according to the CQC's five key areas. The response had been "outstanding" or "good" in safe, effective, caring, and responsive. In well-led the response was 95% "outstanding" or "good". The provider was aware that one person had requested a change of room which they had not been able to accommodate at the time.

Comments on the provider's quality questionnaire for people living at the home were all positive. One comment read, "Everything possible is done for people's health and welfare with love and kindness." Suggestions for improvement had been followed up, such as providing more shade in the enclosed courtyard garden, and arranging a computer link for people's families to take part is meetings if they were not able to travel to the home. At the time of our inspection the provider was recruiting an in-house physiotherapist in response to another suggestion.

There was a monthly review and audit of people's care. This included their capacity, nutrition, weight, GP visits, any accidents, pressure injuries, changes to their dependency level and any concerns or issues. The registered manager reported to the provider monthly. Their report covered people using the service, a clinical review of their care plans, staff and training, and nursing and care hours provided.
Other regular checks included a mattress audit, checks on laundry, domestic cleaning and carpet cleaning. There was a daily maintenance schedule with a maintenance workbook which showed jobs requested and when they were completed. There were routine checks on slings, wheelchairs, scales, electrical appliances and curtain tracks. There were unannounced spot checks on hand hygiene.

A legionella risk assessment carried out by an external supplier had identified actions to reduce the risk of this bacterial infection. The actions had been completed and confirmed at subsequent audits in April and October 2016. The provider undertook an annual infection control audit. In June 2016 this had resulted in a score of 98%, an increase from 92% in the previous year. The provider used internal and external checks and audits to improve the quality of service.