Molescroft Nursing Home (Holdings) Limited

Beverley Grange Nursing Home

Inspection report

Lockwood Road
Molescroft
Beverley
HU17 9GQ
Tel: 01482 679955
Website: N/A

Date of inspection visit: 10 March 2015
Date of publication: 19/06/2015

Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 10 March 2015 and was unannounced. The last visit of the service was on 5 August 2014 when the service was found to be in breach of legal requirements. These were in relation to staffing, safeguarding of vulnerable people and medicine management. We had received information from the provider after this visit to declare they had taken actions and now met the legal requirements. Consequently this visit included a review of the action taken and found the provider had met all of the legal requirements.

Beverley Grange is a purpose built home situated on a housing development in a residential area on the outskirts of Beverley. It is set in its own grounds with plenty of space for people to sit and enjoy the fresh air.

Summary of findings

The service was opened in 1999 and provides long term and respite stays, looking after people who need residential care or nursing care. Respite stays are usually short periods at the home often used to allow people time to recover from illnesses or injuries.

At the time of the visit 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.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. DoLS are part of the Mental Capacity Act (MCA) 2005 legislation which is in place for people who are unable to make decisions for them. The legislation is designed to make sure any decisions are made in the person's best interest. We found people were supported with this.

People living in the home told us they felt safe. People had risk assessments in place which identified any risk in their lives and helped prevent harm occurring. People were supported by staff who had been trained in and knew what actions to take should an allegation of harm be raised.

People were supported by staff who had been recruited through a system which required only minor improvements. We received some comments whereby people felt there could be more staff in the home although people told us their needs were met.

People received support to help make sure their rights were respected. Staff had received training in the Mental Capacity Act (MCA) although not all staff were clear on their understanding of this.

People felt staff were competent in their role and staff had received training.

People's nutritional needs were identified and supported, although support with the eating of meals required improvement. People's health and medication needs were identified and met. When necessary people accessed support and advice from health care professionals.

People were supported by staff who were caring and polite. People living in the home told us staff supported them with their independence and their privacy and dignity was respected.

Not everyone living in the home felt the manager responded well to requests. However, people did feel there was a good atmosphere in the home. Staff felt they received good support from managers.

Audits were undertaken of the systems within the home to help make sure people's needs were safely met. However, not everyone felt consulted.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service is safe. Only minor improvement is required.

We found that action had been taken to improve medication systems, systems to protect people from harm and staffing.

People felt safe and were protected from harm.

Staff recruitment required minor improvement; although feedback about staffing levels had improved, not everyone felt there were enough staff to meet people's needs.

People were supported with their medication needs.

Good

Is the service effective?
The service is not always effective.

People felt supported by competent and trained staff.

Latest guidelines for people with dementia needs were not in use in the service.

Peoples nutritional and health needs were met. However, support with the eating of meals required improvement.

Requires Improvement

Is the service caring?
The service is caring.

Staff were caring and polite. People were supported with their independence and had their privacy and dignity respected.

Good

Is the service responsive?
The service is responsive.

People were supported with choices.

People had care plans in place to help identify their needs and recognise the support required.

There was a system in place for handling complaints.

Good

Is the service well-led?
The service is not always well led.

Not everyone felt their requests were responded to well.

People felt there was a good atmosphere in the home but not everyone felt consulted.

Good

Beverley Grange 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.

We also checked that improvements to meet legal requirements planned by the provider after our comprehensive inspection of 5 August 2014 had been made. This is because the service was not meeting some legal requirements.

This inspection took place on 10 March 2015 and was unannounced.

The inspection team consisted of two inspectors a specialist advisor 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. The person's area of expertise was for services for older people.

Prior to the visit we reviewed the information we held regarding the service and this included information we had received from the registered provider. This can include a provider information return (PIR) although this was not requested on this occasion. A PIR is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spent time talking with ten people who lived in the home, spoke with six visitors to the home, five staff, the registered manager and two general managers.

We observed daily life, reviewed the care files for six people who lived in the home, four staff files, medication records and other records in relation to the management of the home. We spoke with two professionals.

Good

Is the service safe?

Our findings

At the last inspection of 5 August 2014 we found the service was not meeting legislation in relation to protecting people from harm, staffing and medicine management. At this visit we found that the service had taken action to meet this legislation and our findings are described below.

We asked people who lived in the home to tell us about the home. We received a variety of comments which included, “I am quite happy here, it's company, you’re not alone”, “It’s alright, comfortable for what it is" and "Generally speaking it’s okay". Another person said "Very good, it's a happy place" and "Carers are good". Although one person did say they were bored.

When we asked people if they felt safe they told us “Yes, there is always someone around, you don't feel alone", "I think the people here all look after you, I close my door and it's my room", "I feel safe, it’s a nice atmosphere", "No one’s going to harm me" and "I feel safe, I feel protected".

We also asked visitors if they felt people were safe, they told us "Totally safe" and "No issues here", "I have never seen otherwise"

A visiting professional fedback, ‘I feel that this home is well led and safe, I am not aware of any issues or problems within this environment – it is well managed’.

People’s files included details of risk assessments which helped them to live their lives safely; these included the risk associated with moving and handling, the risk of pressure sores, falls and choking. One person required the use of oxygen and we saw a risk assessment had been undertaken and was available in the person’s notes. We checked the storage of the oxygen and found it to be appropriately stored with a relevant safety poster to warn people it was there. We also saw risk assessments were available for the use of bed rails in order to promote patient safety without excessive restriction for people. Additionally there was evidence that nationally recognised risk assessment tools e.g., Waterlow score were used to support people. These helped to identify people’s needs and risks.

There was a policy held in the home which provided advice to staff on how to handle any concerns regarding the safeguarding of vulnerable people. When we spoke with staff they were confident they would raise any concerns with more senior staff and that these would be handled appropriately. They also told us and records confirmed they had undertaken training in relation to safeguarding of vulnerable adults (SOVA). This meant people were supported by staff who were trained and who had access to information on how to support someone should an allegation of this nature be raised.

We reviewed the information we had received about the home including consulting with a professional. We did not receive any concerns in relation to the handling of safeguarding concerns.

There was a system in place for the recruitment of staff which included evidence of previous employment, references and Disclosure and Barring Service checks (DBS). We looked at three staff files and saw that in one instance there was a gap in the dates of employment with no recorded evidence this had been reviewed by the home. In feedback the provider confirmed to us this had been checked verbally.

One person had recently left an employment and there was no reason given for this, with no recorded evidence of an explanation being sought as part of the recruitment process. In feedback we were provided with a sample list of staff who had left the home and the reason for doing so.

One member of staff had a DBS check which had been cut or torn in half and then sellotaped together again there was no explanation for this and it was not possible to verify if the two parts matched. However, one of the home managers had completed a separate check which confirmed there were no concerns with the DBS check.

We asked people living in the home about the staffing levels. They told us “There is always someone, but I try not to worry them”, "I get a bath often and I get my hair done every week", “Sometimes I have thought there should be more staff on" and they added that they thought all staff were hardworking. People also said about sufficient staffing levels, “I think so” and “Yesterday there were only two staff on" adding that they didn't think this was enough. They said they had pressed the call button at 1.30pm yesterday and one carer came in and told her they would have to wait as she couldn't assist her on her own and that the other carers were on a lunch break. The person had a half hour wait. This person added that "Nights are okay" and "I have had a shower and a hair wash today". Another

Good

Is the service safe?

person said “Staff are available to help me with bathing but they sometimes seem short of staff”. The provider confirmed in feedback there were no occasions when there are only two staff on duty.

When we asked visitors if the staffing levels were acceptable, they told us "On the whole yes, occasionally I wonder where they are”, "No, when I first started visiting here about four years ago there seemed more staff" and "They are here if you need something” and "Usually, there are odd times, usually in a morning, particularly at weekends when there are less staff".

One member of staff told us they felt there were not enough staff on duty each day. They told us medication was not delayed but that personal care, for example baths were. They explained that it was 24 hour care and tasks would be completed over the 24 hours. They told us how on occasions staff missed their breaks as they were too busy. Another staff said there were enough staff “Most of the time.”

When we spoke with one professional they told us they had no concerns with staffing in the home and that the home had recently reviewed staff deployment to help make staffing more effective.

We looked at the duty rotas and saw that each day there would be one nurse on duty and nine care staff. This included a senior care and floor manager. In addition there was domestic, laundry and catering staff employed in the home. On the day of the visit the registered manager was working as the nurse on duty in order to cover sickness within the home.

We asked people about the support they received with their medication and they told us their tablets were on time and if they were in pain, for example with headache staff would give them painkillers. They said “I get them at the same time every day”, “They are brought to me" and “I get my pills sorted and they come in the morning".

There was a medication policy held within the home which recorded that staff who administered medication would receive annual training and an annual observed practice to help make sure they handled medicines correctly. We saw that people had completed medication training and when we spoke with staff they confirmed this to us.

We saw that people who lived in the home had individual medication records. Some people’s initial assessment when they moved into the home included details of their health and medication associated needs. When necessary risk assessments had been completed and care plans developed to record why a person required medication and any possible side effects from this. However, we did find some minor improvements were required with the consistency of these records to help make sure everyone received the same recorded support. For example, one person had an assessment for the self-administration of medication; this had not been recorded in their assessment when they moved into the home. Another person had a care plan to help support them with managing pain but this did not include the detail of their medication. A third person had a medication profile which included a list of medication but which did not record what they medication was actually prescribed for.

We saw medication was stored safely and that temperatures were taken to help ensure medication was kept at the required temperature and was not compromised.

We also saw there was a system in place for the safe disposal of medication which included that documents were signed to record when medication had been received by the pharmacist. When we checked stock balances of medication we found that these matched with the amounts recorded as ‘in stock’.

Any medication which was described as controlled’ or ‘CD’ were stored safely and records were appropriate.

We saw the manager had completed audits of the medication to identify any areas of improvement and help ensure medication systems remained safe.

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected.

The manager told us about one person who had a DoLS authorised; this supported them with maintaining their rights.

There was evidence that restrictions were minimised so that people felt safe but also had as much freedom as possible. For example, one person used a bucket type chair slightly tilted; this restricted them but had been authorised through DoLS. We also saw that people's files included their photographs and people had been asked about and consented for these to be kept.

When we spoke with staff, four people told us they had attended training in MCA and their training records confirmed this. However, when we spoke with staff not all staff were aware what MCA was and how it supported people. None of the staff discussed people's capacity for assessment and one person stated that a power of attorney gave authority for decisions about restrictions in people's lives. We did see that people's files included a mental capacity assessment and that medical forms were completed correctly. We also saw that the home had reviewed their policies and procedures in line with equality and human rights legislation.

When we asked people who lived in the home if they felt staff had the right skills to support them they told us "Yes I think so, they are good", "I think they are competent", "On the whole, yes, they are" and "I think so, they vary, some are better than others".

The registered manager told us they followed latest best practice guidance from the National institute of Clinical Excellence (NICE) and attended training provided by the local authority. Some people living in the home were supported with dementia needs and the manager confirmed they did not access any additional guidance for people with these needs. For example, changes to the environment. The manager did confirm the provider was going to consider this when they undertook any refurbishment to the property/premises. In feedback the provider informed us additional guidance was accessed via the providers' sister home and through accessing professional organisations.

We reviewed staff training records which included a staff training matrix and individual records. We saw staff attended a variety of training which included fire, equality and diversity and person centred care. When we spoke with staff all but one person could recall the training they had completed in the last year. Two staff told us "We have received training which includes health and safety and infection control." When asked about what training they had received one member of staff said "Loads."

We asked staff about supervision sessions with the registered manager of the service. Some but not all staff could recall attending these sessions with the registered manager. One staff member said they had not received a formal supervision in two years. For three people there were records of one supervision, within the last year. However, staff told us about informal supervision and that the registered manager would check they had no problems. Additionally another manager told us how staff had received supervision and this was an issue with record keeping only.

We asked people about the food provided by the service and their choices. Some people said the food was "Okay" and" Quite varied". People told us they had drinks brought to them and they could choose to go to the dining room. However, one person said "There is not a great deal of choice and they could do with a cook with some imagination, as the food is boring" and another person said the food was "Ordinary".

We asked visitors about how people's dietary needs were met. One person told us how their relative had previously lost a lot of weight but was now stabilised.

People's files included an assessment of their nutritional needs and monitoring forms for their weight. This helped to make sure any needs were identified and people's nutritional health was monitored.

We observed the lunch in two dining rooms and saw people had a choice of meals. Staff explained the kitchen staff would ask each person each day what their choice was from the menu. We saw people could choose from hotpot or fishcake although one person had scampi as they did

Is the service effective?

not like either of these choices. Details of people's dietary preferences were noted in their records. This helped to make sure staff were aware of these and people's needs were met.

We saw when necessary people had additional aids for example, a guard around a plate to assist them when eating their meal. When necessary people received softer food or pureed food to help them eat.

We observed that lunchtime was extremely busy. Some people required staff to assist them with eating their meal and we saw one staff member sit with someone to help them eat. We also saw a staff member stand next to someone to help them eat and another staff member shared their time standing next to two individual people supporting them both at the same time. Supporting someone in this way is not considered best practice. However, we did observe staff were polite, considerate and caring with people when they were talking to them and supporting them.

We asked people about the support they received with their health needs. We were told that staff would ring the GP if they were unwell and that staff would "Get a nurse to assess me first".

Visitors also told us staff contacted people's health professionals as necessary. They commented, "Yes, the GP was here yesterday, very accessible" and "Yes, we have now changed to a Beverley GP and I have had no input on this".

There was evidence in people's notes of information about their physical, social and psychological needs. Any medical conditions were clearly stated together with a list of any medications. We saw that when necessary risk assessments had been completed to assist with the meeting of health needs. Information was recorded in people's care plans to ensure the correct management of any medical devices. This helped to make sure people received the correct support with meeting their health needs.

Additionally there was evidence that when people's physical needs changed they were supported to seek additional medical advice, for example to be seen by their GP. When this included a short course of treatment, for example antibiotics, a care plan was developed to support them with this.

There was evidence of close monitoring of peoples medical and psychological condition to ensure that any necessary interventions were undertaken, for example, one care plan highlighted that the person may have had an infection, what the possible cause was and that a GP assessment had been requested with the person being prescribed antibiotics. .

We observed two peoples care and noted this appeared to be in line with their care plans. For example, one person's care plan identified the need for a pressure relieving mattress due to a medical condition and this was found to be in place.

Good

Is the service caring?

Our findings

We asked visitors about staff skills and their relationships with people, they told us "Trained staff are very good, some of the carers are better than others, taken as a whole I have no issues", "I have observed a caring approach from staff", “I would say so, although it is difficult to say", “They seem to cope alright, I feel staff like X" and “They never complain or make you feel like you are a nuisance".

One person living in the home commented that “The staff here are very kind and well trained; they always know what to do and are very tolerant”. Other comments from people included, “Staff are nice and never rude to me,” “I think they are caring”, "They know my name, it's only a job for them" and "I do think they care about me".

One relative stated “I think this nursing home is very good, its bright and clean and they have things to keep people busy – I haven’t seen anything that worries me”. Another relative told us how they had taken a long time in choosing somewhere for their relative to live and that they were happy with the care provided by the staff in the service. Another relative complimented staff on the support they and their family had received when their relative was close to the end of their life.

Some of the people living in the home also told us they were involved in making decisions about their care. Comments included "They generally help me and if I were to ask them for anything they would do it”, “Staff explain things to me”, “I would say so yes” and “No, I take it as they give it to me".

The registered manager told us the reason the home was ‘Outstanding’ was due to the care and compassion of the nursing and care staff.

When we spoke with staff they were knowledgeable about the needs of the people who lived in the home. They knew peoples personal preferences and likes regarding their care. They were aware of past health needs and how these were to be met in the home.

People living in the home told us they felt staff respected their privacy. People said “Yes I feel they do” and “As far as possible but there are never enough staff.” One person commented that staff “Weren’t bad”. Visitors also confirmed that staff respected people’s privacy and commented “I would say so, if they see me here they usually leave us alone come back" and “As far as it is possible".

Staff gave us example of how they maintained people’s privacy and dignity in the home. This included for example, they made sure curtains and doors were closed when personal care was taking place and how they respected the wishes of the individual.

We observed people being treated with kindness and respect. Carers appeared to take time to talk to people and spend time with them. We observed people’s dignity being maintained, for example doors of rooms were closed when personal care was taking place.

We also saw that people’s records were stored in a locked area accessed by staff only; this helped to maintain confidentiality and people’s privacy.

Good

Is the service responsive?

Our findings

When we asked people if they were involved in decisions and had choices they told us “I think staff make the choices and I try to fit in", “I think so, I choose when to get up and go to breakfast when I am ready", “Yes within reason" and “I do, I'm known as the woman who never leaves her room which is what I want".

People told us staff supported them to be independent and comments included “I am quite independent, I dress myself and I can walk about on my own" and “I don’t feel restricted at all".

The majority of the people living in the home felt staff knew their needs, as comments included, “I think they know me" and "I do, all of them know what I need, I have been here a number of years and I am part of the furniture now". However, one person commented “Not particularly as there aren't enough of them and staff are all different".

Visitors told us they felt people’s needs were met and one comment included “I'd say yes, met well enough, he is not neglected and staff like him".

People received personalised care and support. We found that peoples’ care plans were all in a similar format and were easy to access. They all included an admission assessment to determine the person’s needs prior to moving in to the home. The care plans covered a variety of areas for example, communication, personal hygiene, breathing, sleeping, mental health & cognition and cultural, spiritual and social hopes and concerns. This helped to make sure they were comprehensive and included all of the person’s needs.

There was evidence that care plans were regularly reviewed and staff signed to confirm when this had been completed. Additionally there was evidence that family members and individuals were included in their care planning and this was clearly documented with times and dates. There were concise records of discussions between family/carer and nursing staff.

The service helped protect people from social isolation as we observed visitors regularly accessed the home. We spoke with visitors who were clearly involved in people’s lives.

Visitors talked about being involved in decisions with their relatives care. They told us “I am involved in decisions, such as there are any to make, as life is pretty routine”, “I am the one who makes decisions but as yet I’ve not been asked to make any" and "My X is also involved".

Information relating to the people’s religious and spiritual requirements were clearly detailed with contact details if required. This helped to make sure these needs were known and supported.

We asked people about activities available to them. People told us “I walk down and sit in the foyer, but I don’t do any activities”, "I like doing crosswords", “There are some but they don’t really suit me", "Some people have some games and they are there if I want it", "I would like more one to one time" and "I like walking around the garden but I am not safe on my own.”

On the morning of the visit we observed that some people joined in with a beach ball being passed around to music in the foyer and later in the day a singer entertained people.

Evidence of activities was available documented on a timetable available for people who lived in the home. People’s records included details of the activities they participated in.

People told us they felt able to raise any concerns or complaints with staff. They told us “I would see one of the carers, I would feel alright about it”, "I try not to complain" and "I would go and see staff in the office but I’ve never made a complaint". Another person said “I would tell the carers but the girls are lovely and friendly”.

We also asked if people had made complaints had they been happy with the response they received? One person commented, “Yes I think so". Visitors also confirmed to us they felt able to raise any concerns or complaints.

We saw that records were kept of complaints received into the home; these were dated and included the details of responses given.

Good

Is the service well-led?

Our findings

There was a registered manager in post in the home. When we spoke with staff they confirmed the manager was approachable. They said “We enjoy working for the home and think that the managers and staff support us well” and “We wouldn’t be afraid to raise any concerns.” Another staff member said of the manager “She is easy to go to, she is very good and deals with problems.” All staff we spoke with confirmed the home had a whistleblowing policy, which assisted them to raise concerns.

We asked people who lived in the home if they felt the home was well managed and they commented, "I think it is nice and friendly, staff know what they are doing", "No, she (the manager) always says things like 'I will get someone to take you for a walk' but it never happens", "She talks a lot", "Could be better", "I never see the Manager so can’t say" and "I don’t really know, but things arrive at the right time".

Staff told us that staff meetings took place but that they did not always attend these. We were told that when staff were on duty they were too busy to attend and that ‘days off’ were precious so they did not come in to attend meetings on their days off.

People living in the home told us about the atmosphere and if this was positive. They said, “Its friendly and there's company for me," "Maybe, I suppose it is positive, but everyone is so busy" and "The home feels friendly, but I stay in my room".

Visitors told us they could approach the manager and staff and said there was a good culture in the home. Their comments included "Yes I feel there is, I once asked staff to clean the carpet in X’s bedroom and this was done immediately".

We saw there was a range of policies, procedures and guidelines available for staff reference. These included a policy on care planning which linked to peoples care plans and which we viewed at the time of the visit. Other policies included for example, health & safety and quality assurance. These policies were relevant to the service and in line with national guidance.

The manager told us about some of the audits they completed in the home. This included a care plan audit. However, when we reviewed people’s files we saw that not everyone had had pre-assessment information, patient passport and /or transfer sheets added to their files although it was stated that transfer sheets were used. We were informed that the forms were not always returned with the person from the other healthcare setting.

Other audits were available in the audit folder and these included audits of lifting slings in use in the home, hand hygiene, activities, the environment, accident records and a business continuity plan. Any accidents were recorded. Additionally the manger had introduced and adapted audits of medication used within the home to help ensure these systems remained safe.

We asked people who lived in the home how they were asked for feedback and if this included completing surveys. People told us "No one has ever asked me", “I might have done a survey" , " there are no residents meetings", “No never, no meetings" and "Yes someone filled in a questionnaire for me". None of the visitors we spoke with had received a satisfaction survey. We saw there were questionnaires sent to people who used the home and their representatives, although these had no dates of when they were completed. One of the managers told us they had been received at the end of January and they had as yet to compile a summary of the findings from them. The provider forwarded graphs showing the feedback results and an action plan for changes to the home in response to the survey results.

When we reviewed people’s files we saw evidence of how the managers and staff worked with other professionals to help make sure people’s needs were met. This included collaboration at best interest decision making and care planning meetings. We saw that GPs and district nurses visited the home and one professional told us about their positive views of the home.