DRB Healthcare Limited

Beech Tree Care Home

Inspection report

Sprents Lane
Overton
Basingstoke
Hampshire
RG25 3HX

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13 February 2018

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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

This inspection took place on 9 and 13 February and was unannounced. This was the first inspection since Select Healthcare Group took over responsibility for regulated activities at Beech Tree Care Home.

Beech Tree Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of the inspection there were 47 people living in the home. There were three floors. People with nursing needs were cared for on the ground floor and first floor. On the second residential floor people received personal care.

The service had a registered manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection in May 2015, we asked the provider to take action to make improvements to maintain the safety of people living with diabetes and this action has been completed.

Systems were in place to protect people from avoidable harm and abuse. Staff were aware of their responsibilities and had received the required safeguarding training. There were sufficient numbers of staff to support people's basic needs and keep them safe. There were safe recruitment processes 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, record and administer medicines safely.

People received care from skilled staff who had received the appropriate supervision and training. Staff were given regular supervision and training to help develop their knowledge.

Staff were aware of the legal protections in place to protect people who lacked mental capacity to make decisions about their care and support.

Plans were in place to ensure that people had enough to eat and drink to maintain a balanced diet. High calorie snacks and drinks were available for those at risk of malnutrition. People were supported to access care from relevant healthcare professionals.

Carers had positive, caring relationships with the people they cared for. Staff encouraged people to express themselves and supported their independence, privacy and dignity.

Care plans reflected care and support that people required and were written in partnership with people and their families. Some care plans lacked more specific details about people's preferences for how they would like to receive their care.

The provider had processes in place for investigating and responding to complaints and concerns.

The provider had begun to implement plans for delivering end of life care for people. Staff had undertaken end of life care training and an end of life register had been put in place to assist staff in monitoring people if they were in need of end of life care.

Systems were in place for monitoring efficiency and quality within the service so that improvements could be made.

The provider worked in partnership with a number of healthcare professionals to drive improvements in 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

Systems and processes were in place to protect people from the risk of abuse and from avoidable harm

The provider employed sufficient numbers of suitably qualified staff to meet people's needs. Recruitment checks were carried out to make sure staff were suitable to work in a care setting.

Processes were in place to ensure medicines were stored and administered safely.

People were protected from the spread of infection.

The provider kept records of accidents and incidents and reflected on these to improve care.

Is the service effective?

Good

The service was effective.

People's needs were met by staff who had the appropriate skills and knowledge

Staff were trained in the Mental Capacity Act 2005 and were aware of how to apply its principles.

People were supported to access healthcare services as needed.

Arrangements were in place to support people to eat and drink enough to maintain a balanced diet.

The environment was suitably adapted for the people living there.

Staff sought consent from people before carrying out any care or treatment.

Is the service caring?

Good

The service was caring.

Staff developed caring relationships with the people they supported.

People were supported to express their views.

Staff understood the principles of privacy and dignity and supported people to maintain this.

Is the service responsive?

Good

The service was responsive

People received care which was adapted to their needs.

People's concerns and complaints were responded to and dealt with promptly

Plans were in place to provide end of life care to those who required it.

Is the service well-led?

Good

The service was well led.

The registered manager maintained a supportive culture and displayed strong leadership.

There were effective systems in place for monitoring the quality of the service.

The provider used a number of methods to involve people, relatives and staff in decisions about the service.

The provider worked in partnership with other? professionals to deliver people's care.

Beech Tree Care 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 9 and 13 February and was unannounced. The inspection team included one inspector and one 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 expert by experience's area of expertise was care of people with a learning disability.

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 reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with nine people who used the service, ten care staff, one health professional, one member of cleaning staff, a cook, the registered manager, and the deputy manager. We reviewed records which included seven people's care plans, three staff recruitment files and supervision records and records relating to the management of the service.

We also reviewed records relating to staffing levels, risk assessments, quality assurance and policies and procedures. We also looked at meeting minutes for staff, people and relatives.

After the inspection we reviewed additional records sent to us by the provider. These included end of life care plans for three people.

Good

Is the service safe?

Our findings

At our last inspection in May 2015 we found that the provider had not taken all practical steps to manage risks for people living with diabetes. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the provider had suitable arrangements in place for managing risks for people living with diabetes. Nurses in the home monitored blood sugar levels of those living with diabetes at regular intervals and there was a hypoglycaemia (low blood sugar) kit available for emergency use. Staff followed the provider's policies when monitoring people for signs of low blood sugar and reported any changes directly to nurses. The deputy manager told us that they were promoting a hypoglycaemic awareness week in the home and that they were delivering training to staff in this area.

People living in the home told us they felt safe. One person told us, "I feel very happy here and very safe." Another person said, "I do feel safe, they do look after me." People were safeguarded from avoidable harm and abuse. The provider had policies in place for safeguarding and whistleblowing. When concerns were raised about safeguarding they notified the local authority and the Care Quality Commission.

Staff received face to face safeguarding training during induction. This was refreshed each year and was supported by online training. Staff showed thorough knowledge of safeguarding practices. They were able to identify different signs of abuse and actions to take if someone was at risk of harm. Staff were aware of who to go to with concerns and of the procedures to follow to escalate concerns if they felt they were not being addressed by the provider.

The provider ensured that there were the minimum numbers of staff to meet people's needs. An electronic dependency tool was used to plan the number of staff needed. This identified the number of care hours required by each person living in the home and the number of staff required to deliver care. The provider relied on agency staff to cover shortages and was recruiting for vacant staff positions.

There were robust recruitment checks in place to ensure that only staff who were suitable to work in a care setting were employed. Staff files contained evidence of two previous employer references, right to work in the UK and checks with the Disclosure and Barring Service (DBS). A DBS check helps employers make safer recruitment decisions by identifying applicants who may be unsuitable to work with people made vulnerable by their circumstances.

The provider had robust processes in place to ensure people received their medicines safely. When people received support with taking prescribed medication this was documented in their care plan. People's medication administration records (MARs) were accurate and clear. Allergies were recorded on MAR charts and there were clear instructions for staff on how to apply topical creams. Creams and ointments were included on MAR charts and body maps were used to indicate where these should be applied. There were clear directions for staff on how to administer 'as required' medicines to people. Medicines were given by

competent staff who had received the appropriate training. Records showed that staff received medicines management updates each year. Competency spot checks were carried out by the deputy manager to ensure that staff were following the correct procedures for giving medicines. There were safe processes in place for storing medicines and for disposing of unused medicines. External pharmacy audits were completed by a local pharmacist to help to identify any risks.

People were protected from the spread of infection. Staff followed the provider's infection control policy and used personal protective equipment (PPE) when delivering personal care to people. Staff demonstrated that they understood the risks posed to people by the spread of infection and were able to identify ways to prevent infection. Clinical waste was disposed of in the appropriate bins and waste disposal areas were clean. Records showed that infection control audits were completed monthly and daily cleaning schedules were fully completed. The deputy manager was the designated lead for infection control. At the time of the inspection they were delivering handwashing training to staff to ensure that they were aware of the importance of using the correct handwashing technique as a means of preventing the spread of infection.

The provider kept records of accidents and incidents and used these to reflect on ways to improve care and prevent further incidents. For example, the provider had identified preventative measures to reduce unwitnessed falls. As a result of analysing the circumstances leading up to falls the provider had identified people in need of further support or supervision to maintain their safety. Devices such as sensor mats had been placed in people's rooms so that staff could be alerted immediately to people's movements if they required assistance.

The registered manager told us that accidents and incidents were discussed in daily handovers as well as in staff meetings to encourage staff to reflect on ways to ensure people's safety. This was confirmed by records.

Good

Is the service effective?

Our findings

People's needs and choices were assessed and documented. Before arriving at the home people received an assessment visit from the deputy manager. Assessments were completed in partnership with people and with family members with people's consent. They included details of people's life histories, important relationships, preferences and needs. There was evidence in care plans which showed assessments had been completed with people's consent. Most of the care plans we reviewed contained appropriate guidance to help staff support people according to their preferences, however two care plans would benefit from more detailed information about how people could be supported in their preferences and in ways to maintain important relationships.

People's care plans contained assessments which supported their physical and mental health. One person's care plan contained specific guidance around safe diabetes care, including information on normal blood glucose levels and signs of hypoglycaemia or hyperglycaemia, also known as high or low blood glucose levels and actions staff should take if they observed these symptoms. Another person's care plan contained information for staff about how to support them with feelings of anxiety. The person's care plan also contained records of visits from the community mental health nurse.

The provider had a named nurse and keyworker system in place. This was to ensure that staff liaised with the appropriate professionals to support people's health needs. There was evidence that this system was effective as records showed that care plans were reviewed monthly and people were being visited by the relevant healthcare professionals such as district nurses if they required support to manage their health needs.

The provider delivered a comprehensive induction programme for all staff as well as yearly updates. All staff had completed their mandatory training. This was confirmed in the staff training matrix. Eight members of staff were undertaking the Care Certificate, which is an agreed set of standards which sets out the expectations for the knowledge, skills and behaviours of those who work in health and social care.

Records confirmed the registered manager maintained an up to date log of staff appraisals and bi-monthly supervisions. These were contained in staff's continuous professional development files. Staff files also contained training certificates for courses completed, such as for swallowing difficulty awareness, dementia care and person centred care. The registered manager told us that they completed 'spot checks' on staff to support them with learning needs.

People were supported to eat and drink enough to maintain a balanced diet. Screening tools were completed and reviewed monthly to identify anyone at risk of malnutrition. Each person's care plan contained a nutritional risk assessment. The provider had worked with a speech and language therapist to plan appropriate menus for people at risk of swallowing difficulties. People's weights were monitored monthly and high calorie drinks and snacks were offered to people identified as being at risk of weight loss.

Staff worked effectively with different professionals to meet people's needs. Care plans contained evidence

of contact with opticians, GPs and nurses. A chiropodist visited each resident in the home every six to eight weeks, this was confirmed by records. A local GP completed a doctor's round at the home once a week. Nurses at the home identified people in need of a GP review and documented this in people's care records. This ensured that people's health needs and long term conditions were monitored, enabling staff to meet people's health needs.

People's care plans contained care passports which were used to share relevant information with healthcare professionals if they were admitted to hospital. This was done with the person's consent. Health professionals were required to complete these before people returned home to ensure a safe discharge and prevent them being readmitted to hospital.

People were supported to have healthy lives and to access healthcare support as they needed it. There were records in care plans of visits to healthcare professionals such as dentists and opticians. The registered manager had nominated a continence lead whose role was to identify people in need of support and complete referrals to the continence nurses. This helped to ensure that people received timely support for their health needs.

The home was suitable for people's needs. The home consisted of a ground floor and first and second floors. Different floors could be accessed using lifts. Corridors, doorways and rooms were sufficiently wide enough to allow wheelchair access. Each room had an en-suite bathroom so that people could access the toilet easily. At the time of the inspection the registered manager was having rooms in the home redecorated to make them more suitable for people living with dementia. This work had not yet been completed.

Staff had received training on the Mental Capacity Act (2005). Staff were observed gaining people's consent before delivering care and were confident in identifying ways to maintain people's privacy and dignity.

The provider had complied with the requirements of the Mental Capacity Act (2005) 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. 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 are called the Deprivation of Liberty Safeguards.

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.

Where people were at risk of being deprived of their liberty, the registered manager had made the appropriate applications. The provider maintained a record of these applications which were due to be approved. Care plans also contained records of best interest decisions made on behalf of people for consent to treatments and to share information with healthcare professionals.

Good

Is the service caring?

Our findings

People we spoke with told us about the positive relationships they had with the staff who cared for them. One person told us, "They [staff] really are quite wonderful." Another person said, "I think staff do all they can for me." Relatives gave positive feedback about the care their loved ones received. One relative reported, "Beech Tree has always been a welcoming place and the atmosphere a very happy one." A healthcare professional we spoke with told us, "Speaking to families there's a real sense of trust and peace. The residents seem happy." Thank you cards and notes praised the staff for their caring approach.

Staff treated people in a kind and compassionate manner. During an activity session we observed a staff member speaking to people in a friendly way, taking interest in what they were saying and asking them if there was anything they wanted or needed. They interacted in a positive and inclusive way and clearly knew the people they were caring for well. People were laughing, smiling and joking with this member of staff.

Staff members took time to speak to residents, including those responsible for cleaning and cooking. This showed that the caring approach was shared by the whole home. One staff member told us, "I come out in the dining room and have a chat." Another staff member said, "I go and talk to them, generally talk. It's that bond you've got."

At lunchtime we observed people were supported to come in gradually. This meant that people were not rushed and were able to sit down at their own pace. People were given a choice about where they wanted to sit. Where people were not able to communicate verbally, staff sat people next those they got along with. The atmosphere in the dining room was calm and relaxed. Staff were caring and attentive to people's needs.

One person's care plan stated that they suffered with tunnel vision and were not able to see people if they stood to the side of them. During lunchtime a member of staff sat directly in front of this person so they could support them with eating.

Staff we spoke with demonstrated a clear understanding of the importance of treating people in a caring manner. Staff demonstrated that they understood the importance of encouraging people to express their views. One staff member told us, "You give them time to tell you what they want." Another staff member told us, "I treat them how I would want a member of my family to be treated. We always explain what we're doing." Staff gave us examples of how people should be treated with privacy and dignity. These included knocking before entering someone's room and ensuring people were covered when they were receiving personal care. When people required help with personal care, staff were discreet, supporting people to the toilet in a calm and unhurried manner.

The registered manager told us that relatives were welcome in the home and encouraged to visit at any time. During the inspection we observed several relatives attending at different times of day. Staff were approachable and had positive interactions with relatives.

Good

Is the service responsive?

Our findings

Most people's care plans contained detailed information about people's care needs and preferences. We noted however that one person's care plan lacked detail about who family members were and the support the person needed to stay in contact with them. Another person's care plan contained details about support required for a visual impairment. There was a lack of specific detail around the person's preferences for personal care. More information would have been beneficial in supporting this person's individual preferences, however their care plan did contain information about how the person could be supported.

The provider gave us an example of how they had provided responsive care. Staff had identified that a person wanted their sexual needs to be met. Staff made arrangements so the person could meet their needs privately. This was included in the person's care plan.

People's cultural and spiritual needs were identified through assessments and supported. As several people were Anglicans, the provider had made an arrangement with a local Anglican church to offer communion in the home once a month. Members of the church were also encouraged to visit people and did so regularly. The provider also had links with Catholic Church. Catholic chaplains visited the home to provide support to people. Staff gave us an example of how they had requested a chaplain to attend to give the 'last rites' to a person.

The service responded to concerns and complaints. In response to a complaint received about communication, the registered manager since implemented a 'you said, we did' board which displayed feedback people gave and the actions the service had taken in response. There were actions around purchasing new furniture, changes to the laundry system and implementation of a photo board showing residents activities. These were in response to feedback and informal complaints.

During the inspection we observed the registered manager dealing with a complaint from someone living in the home regarding inappropriate equipment. They spoke with the person in a calm, way and gave them time to explore the complaint. Following this we observed the registered manager took immediate action to resolve the complaint by ordering more suitable equipment for the person. Results from a resident's survey indicated that people were unsatisfied with the quality of the food. As a result of this the registered manager had employed a new cook.

At the time of inspection the provider had begun to implement plans to deliver end of life care for people. Staff had taken part in a training programme delivered by a specialist nurse. The provider had developed an end of life register which enabled staff to identify and monitor people who may require end of life care. After the inspection the provider sent us examples of end of life care plans which had been completed for people. People had been involved in the decision making process regarding the care they wished to receive and there was sufficient detail for staff to plan how people's needs would be met. Where people did not have the capacity to be involved in making decisions about their care, family members had been consulted.

The deputy manager had been nominated as the lead for end of life care and had gained a qualification to

deliver the end of life care programme to other staff. Staff displayed an awareness of the need to provide responsive care for people nearing the end of their lives. They also recognised the importance of providing sensitive care to family members.

Good

Is the service well-led?

Our findings

The registered manager had a clear vision to provide person centred care for people. They had implemented a number of improvements to the building such as a new wet room on the ground floor. They described plans to introduce additional activities to ensure that people enjoyed their time living at the home. They told us, "Everything is an experience, people have to embrace everything." The person centred approach to care was shared by staff working in the home.

Staff we spoke with told us that there was a positive atmosphere in the home and that they felt the registered manager was approachable and supportive. One staff member told us, "I love people and it's nice with the older people. It's a good team here." Another person said, "The manager is very approachable, she's a good boss." The registered manager maintained an 'open door policy' and ensured that they spent time on the floor so they could observe care being given and offer support and guidance. The registered manager was supported by a deputy manager who was a registered nurse. The deputy manager took a lead role in supporting staff and maintaining high standards of care through delivering clinical guidance and training. At the time of the inspection the deputy manager was completing training for staff on effective handwashing techniques as a means of preventing the spread of infection.

There were systems in place for monitoring quality within the service. The registered manager identified areas for improvement within the home using a 'live' action plan. This was continually reviewed and updated as actions were completed. The registered manager was supported by regional managers who completed monthly compliance visits. Quarterly monitoring visits were also completed by the provider's regional management team. Following this reports around key aspects of the service to be developed were produced and action plans developed to address areas for improvement.

Comprehensive, monthly audits were in place for monitoring areas such as infection control, medicines, care plan reviews, catering, and health and safety. Audits identified areas for improvement through the use of action plans and there was evidence that these had been addressed. People's care plans contained evidence of monthly reviews. A system was in place for monitoring call bell response times.

Areas of staff responsibility were clearly defined. Registered nurses led clinical care and were supported by team leaders who delegated to care workers. Each member of staff took responsibility for monitoring the health and wellbeing of people and reported changes in people's health to nursing staff promptly.

The management team communicated with staff in various ways. There were a range of formats for staff meetings. These included full monthly staff meetings and smaller group sessions to discuss particular themes or issues. Staff we spoke with felt that these meetings were effective. One staff member told us, "We have meetings, discussing everything. We raise issues and they do respond."

The provider held monthly residents meetings to gather people's feedback on the service in order to drive improvements. In a recent meeting residents asked to have more day trips. There was evidence that this was actioned as trips had been planned using the provider's minibus so that wheelchair users could be

accommodated.

The provider engaged with people's relatives through holding regular meetings as well as inviting them to visit the home. The registered manager maintained open and transparent communications with relatives and invited them to take part in events in the home such as a Christmas party and a Valentine's Day afternoon tea. The results from the most recent relatives' survey indicated that relatives were pleased with the standard of care delivered at the home. The registered manager had also made use of social media to raise the profile of the home and engage the local community.

The registered manager kept a record of accidents and incidents and encouraged staff to reflect on the actions needed to improve care for people and prevent incidents. Several staff were completing health care qualifications including National Vocational Qualifications and the Care Certificate. The registered manager facilitated the continuous professional development of staff and encouraged them to reflect on their daily practice. Senior staff competencies were being developed so that they could take a more active role in areas such as pressure ulcer care.

The provider worked effectively in partnership with a range of professionals. As a means of developing practice to support people living with dementia the registered manager had engaged with a clinical nurse specialist. Management staff attended forums with a range of professionals such as palliative care nurses and clinical commissioners in order to share updates and to seek guidance on ways of improving the quality of care in the home. The management team cooperated with clinical commissioners and specialist nurses during quarterly quality assurance visits. Following the last visit staff were praised for their dedication and enthusiasm.