HC-One Beamish Limited

Acomb Court

Inspection report

Maidens Walk
Hexham
Northumberland
NE46 1EN

Tel: 01434604357
Website: www.hc-one.co.uk

Date of inspection visit:
26 July 2017
28 July 2017

Date of publication:
07 February 2018

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

Acomb Court provides residential and nursing care for up to 76 older persons, some of whom are living with dementia. At the time of our inspection there were 75 people living in the home.

This inspection took place on 26 and 28 July 2017 and was unannounced. The last inspection we carried out at this service was in November 2015 when we found the provider was meeting all of the regulations that we inspected and we rated the service as good.

A new registered manager was in post and the service had been taken over by a new care provider. We were told that communication about the transition to the new provider had been good. Our records showed the new manager had been formally registered with the Care Quality Commission (CQC) since June 2017. 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.

We checked the management of medicines and found safe procedures were in place for the ordering, receipt, storage and administration of medicines. Staff received regular training and competency checks to administer medicines.

The premises were clean and well maintained. Procedures to prevent the spread of infection were followed and a number of checks to the safety of the premises and equipment were carried out. Individual risks to people were assessed and plans were in place to mitigate these. Accidents and incidents were monitored by the registered manager to check for patterns or trends.

There were suitable numbers of staff on duty during the inspection and staff records we checked found recruitment processes helped to protect people from abuse as appropriate checks on applicants were carried out. Staff had received training in the safeguarding of vulnerable adults and knew how to report concerns of a safeguarding nature.

People were generally supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. We found one example of where people's rights and choices had not been supported due to the understanding of staff and training was provided to address this issue. We made a recommendation that the registered manager monitors practice in this area to ensure training is embedded in practice.

Staff received regular training, supervision and appraisals, and new staff completed an induction into the service.

The nutritional needs of people were supported. Assessments were carried out and action taken in the event

of people at risk of malnutrition. People had access to a range of health professionals including GP, dietitian, and other healthcare professionals as required.

Staff were polite and caring towards people. We received positive feedback about the manner of staff from people, relatives and visiting professionals.

Care plans were in the process of being transferred to the standard documentation of the new provider. We found some care plans lacked detail and these were mainly the older style records. The registered manager had recognised this issue and had developed a plan to ensure all care plans were reviewed and updated while being transferred to new documentation. The newer style plans we read contained satisfactory information.

There were mixed views about the availability and suitability of activities. Some people told us they were happy with the activities available while others felt they had reduced. The activities coordinator was absent at the time of the inspection and we received confirmation that activities staff were back on duty following our inspection. We have made a recommendation that the provider monitors satisfaction with activities in light of the mixed feedback we received.

The registered manager carried out a range of meetings, audits and checks to monitor the quality and safety of the service. Staff were recognised for 'going above and beyond' and some had received 'Kindness Awards' from the company in recognition of their efforts.

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 remains safe.	Good
Is the service effective? The service remains effective.	Good
Is the service caring? The service remains caring.	Good
Is the service responsive? The service remains responsive.	Good
Is the service well-led? The service remains well-led.	Good

Acomb Court

Detailed findings

Background to this inspection

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

This inspection took place on 26 and 28 July 2017. The first day of the inspection was unannounced.

The inspection team consisted of one inspector a specialist advisor and an Expert by Experience (ExE). The specialist advisor was a registered nurse with experience in care of older people. An ExE is a person who has personal experience of using or caring for someone who used this type of service.

Before the inspection we reviewed the information we held about the home, in particular notifications about incidents, accidents, safeguarding matters and any deaths. We also spoke with the local authority contracts and safeguarding adults teams. We used the information they provided when planning our inspection.

We spoke with nine people who used the service to obtain their views on the care and support they received and eight relatives. We also spoke with the registered manager, regional manager, a nurse, a housekeeper and four care staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records including; 10 care records for people who used the service, nine medicine administration records (MARs), three records of staff employed at the home, and a variety of records related to the quality and safety of the service.

Before the inspection, we asked the provider to complete 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 took this information into account when planning our inspection.

Good

Is the service safe?

Our findings

People told us they felt safe in the service. Comments included, "I'm very comfortable and safe here, all my bits and pieces are safe too" and "Very, very safe here. The place in general is secure and there's loads of people around." Relatives told us, "As far as we're concerned, [relative] is very safe here, they have a quick reaction to alarm calls" and "The rooms are kept clean and tidy, spillages are cleaned up straight away and nicely maintained."

We checked the management of medicines and found systems were in place to ensure that medicines had been ordered, received, stored, administered and disposed of appropriately. Medicines were securely stored in a locked treatment room and were transported to people in a locked trolley when they were needed.

Medicine stocks were properly recorded when medicines were received into the home and when medicines were carried forward from the previous month. This is necessary so accurate records of medication are available and care workers can monitor when further medication would need to be ordered.

Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. Staff knew the required procedures for managing controlled drugs. We saw from the controlled drugs records that staff had made on the MAR matched the records in the controlled drugs record book and that the stock balance records were correct.

Information about how and when people should receive medicines 'as required' was available although we found one person did not have a care plan in place with regards to their as required Paracetamol. This was immediately rectified.

Clear records were maintained for the application of topical medicines such as creams or lotions. For a medicine that staff administered as a patch, a system was in place for recording the site of application and staff had fully completed this record. This was necessary because the application site needed to be rotated to prevent side effects and irritation.

Appropriate checks were carried out on the safety of the premises including gas and electrical safety checks and fire safety equipment. Bedrails and other equipment used by people was checked regularly and tests were carried out on fire alarm and nurse call systems. Hot water dispensers in the home had automatic locking devices to prevent accidental scalding. We found some decorative boxes, a similar colour to the flooring in the corridor in the Grace dementia care unit. This could have posed a tripping hazard and were immediately removed when we pointed this out.

The premises were clean and well maintained. People told us they were happy with the cleanliness in the home and said, "My room and bathroom are hoovered and cleaned, they do a lovely job." There were no issues with malodour and domestic staff told us, "We have specialist teams to help if we have a problem area but if we can't clean carpets satisfactorily they are replaced." We observed that infection control procedures were followed, and staff told us how they helped to prevent cross infection by using colour

coded cloths and mops. Cleaning materials were safely locked away and staff received training in the Control of Substances Hazardous to Health [COSHH] and followed the appropriate guidelines.

There were suitable numbers of staff on duty. One person told us it could sometimes take a while for their call to be answered, other people told us they were happy with response times. A visiting professional told us there were suitable numbers of staff on duty and said, "There's plenty of staff, there's always someone there to talk to." We observed there were suitable numbers of staff on duty during the inspection, and people were supported in a calm unhurried manner.

A silent call bell system was in place which used a pager. The registered manager held a pager to enable them to monitor call bells.

Individual risks to people were assessed including choking and falls for example. A falls analysis form was in use which checked things such as whether items had been in reach for the person, and if they were wearing appropriate footwear. This was in an attempt to identify the potential causes of falls so risks could be minimised. Accidents and incidents were recorded and audited to monitor for any patterns or trends.

We checked staff recruitment records and found appropriate checks had been carried out prior to people starting work in the service, including references and checks by the Disclosure and Barring Service [DBS]. The DBS checks the suitability of applicants to work with vulnerable people helping employers to make safer recruitment decisions.

A safeguarding policy was in place and staff had received training in the safeguarding of vulnerable adults. Staff knew the process to follow should they have any concerns of a safeguarding nature. A safeguarding log was maintained. The regional manager told us the provider took the safety and welfare of people very seriously and had introduced additional monitoring following a recent television documentary exposing abuse in a home owned by another provider. This included more out of hours unannounced visits by managers and a reminder of the whistleblowing policy for staff.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager held a record or DoLS applications that had been made and those granted. Systems were in place to record expiry and renewal dates. Mental capacity assessments had been completed for people and best interests decisions were recorded where they were deemed to lack capacity. MCA care plans and records varied in quality and detail, and some contained conflicting information. Care plans were in the process of being transferred to the new provider's documentation and we found newly completed care plans to contain up to date relevant information. We spoke with the registered manager and regional manager about this who told us all plans were being reviewed while being transferred and the issues we identified had been addressed by the second day of the inspection.

Staff routinely asked relatives to sign care plans on people's behalf including when they had capacity to sign themselves. We spoke with the registered manager and regional manager about staff understanding of MCA and they wrote to us after the inspection to advise us that additional training in MCA and DoLS had been provided to staff.

We recommend that the quality of care plans and practices related to MCA and DoLS are monitored to ensure this training is embedded into practice.

Staff received regular training, and supervision and appraisals were carried out to ensure staff support and development needs were met. Staff records we saw showed that staff had received regular training considered to be mandatory by the provider, to enable them to provide safe and effective care. Training included moving and handling, health and safety, first aid, death and dying, food hygiene, infection control, fire safety and medicine competency. Staff were also supported to take additional vocational qualifications and all new staff were enrolled in Care Certificate training. The Care Certificate is a benchmark for the induction of new staff. It assesses the fundamental skills, knowledge and behaviours that are required by staff to provide safe, effective, compassionate care.

People were supported with eating and drinking. Assessments had been carried out using a Malnutrition Universal Screening Tool [MUST]. MUST is a five-step screening tool to identify if adults are malnourished or at risk of malnutrition. Systems were in place to ensure people who were identified as being at risk of poor nutrition were supported to maintain their nutritional needs and specialist advice was sought if required.

Staff monitored some people's food and fluid intake to minimise the risk of malnutrition or dehydration. Food charts recorded meals taken each day and included portion sizes. Fluid intake charts were also completed. All charts were fully completed and analysed, which showed staff were effectively monitoring people's intake and taking action, as required. Records included notification to the kitchen regarding food likes, dislikes and dietary needs; this was also signed by the chef. This meant there was good communication between care and catering staff to support people's nutritional well-being.

We sat with people who used the service when they were having lunch. Tables were set attractively with tablecloths, placemats, napkins, condiments and there were at least two choices for each course at lunchtime and choices at tea time. The choices of food were advertised on the menu board outside the dining room, which was displayed so people would have been aware of what was being served before the meal. Most people told us they enjoyed the meals. Comments included, "I always get enough to eat and drink" and "The food is good and they go out of their way to give you what you want food wise." One person was not as keen on the meals and said, "Food is of variable quality, there's lots of beans, lots of soup, lots of baked potatoes with cheese." We passed this feedback on to the registered manager.

People were nicely supported during their meal and encouraged by staff. We observed staff prompting and encouraging people including; ""I've got your soup, are you ready, it looks delicious, it smells nice as well." People were also asked regularly if they were managing, if they would like bread butter, chutney and tea or coffee.

The health needs of people were met. Care records showed details of appointments with, and visits by, health and social care professionals. Staff made sure people accessed other services in cases of emergency, or when people's needs had changed, for example, GPs, community matrons, nurse assessors and chiropodists. Care plans reflected the advice and guidance provided by external health and social care professionals.

Good

Is the service caring?

Our findings

People and their relatives told us staff were caring. Comments from people included, "The staff are all caring, I feel part of a community and not alone" and, "I have a laugh with the staff they are all caring." Relatives told us, "The staff are just lovely. I know they care about [relative], there's an awful lot of love and support there" and "It's a first class place, it has a lovely atmosphere." When asked to name a particularly good aspect of the service, a visiting professional told us, "Customer service; the ability to make people feel welcome." A nurse told us they particularly valued, "The compassion and empathy of the staff and their relationship with residents, I love hearing the laughter from the dining room when staff are with residents, if I can put a smile on someone's face once in a day I've done my job."

We observed staff were caring and attentive towards people. Privacy and dignity was respected and we observed staff knocking on doors and offering assistance discreetly. One person told us, "They always knock and ask; they never just burst in" another said, "Oh yes, the girls knock and always ask. They ask if you want your door open or closed. Dignity and respect come high on the list here." Independence was also promoted and another person added, "My independence is important to me, the girls let me get on with it, but if I need help I get it."

We observed staff approaching people gently and explaining what they were doing. One staff member said, "Do you want me to put the napkin on to keep your clothes clean?" Explanations were provided before moving people to avoid startling them, and reassurance was provided throughout.

Staff received equality and diversity training so were aware of the seven protected characteristics of the Equality Act 2010 namely; age, disability, gender, marital status, race, religion and sexual orientation. People told us they felt treated as equals and involved by staff. One person said, "They take our views into consideration" another said, "The staff will listen and act on it, the acquiesce to my way of doing things."

Staff had received training in end of life care, and a relative we spoke with told us their relation was well supported at this time. A visiting professional told us people received end of life care in the home if that was their wish, they told us, "Staff want to manage people's needs in the current setting when they can."

There was no one using the support of an advocate at the time of the inspection but the registered manager knew how to access this service if necessary. An advocate independently supports people to make and communicate decisions.

Good

Is the service responsive?

Our findings

People told us they were happy with the responsiveness of the service. One person said, "Staff will organise hospital and doctor appointments, they arrange travel and come with me if my daughter can't. They always keep my family fully informed."

A new provider had taken over the service and care records were all being transferred to the new provider's paperwork. Care plans we saw varied in quality, with an improvement being noted in recently transcribed and updated care plans. We spoke with the registered manager about this and they provided us with an action plan they had developed to ensure all plans were fully reviewed during the transfer of information as they had noted some plans lacked detail. We also found some plans lacked detail, especially around mental health needs. The ones we highlighted were updated by the end of our inspection and we saw this work was ongoing.

The care records we looked at contained a pre-admission assessment to assess people's needs before they moved into the home. This ensured that staff could meet people's needs and that the home had the necessary equipment to ensure the person's safety and comfort.

Care plans we saw had been signed by people and their relatives, except for the ones that had been recently updated. People and their relatives told us they were involved in the care planning process and said, "We know there's a care plan in place. Staff inform us of any changes" and "The care plan has been fully explained to us." Care plans were in place to address physical, psychological and social needs.

Care records contained a social profile. This meant that there were details about the person's preferences, interests, people who were significant to them, spirituality and previous lifestyle. This information is particularly important when a person can no longer tell staff themselves about their preferences and enables staff to better respond to the person's needs and enhance their enjoyment of life.

We received mixed views about the activities available. Some people told us activities were limited, others told us they were happy with the activities available and others said they had improved of late. The activities coordinator was absent at the time of the inspection. We were informed after the inspection that activities staff were in post. We found a number of activities had been carried out and were planned, including Tai Chi and a trip to the coast later that week. We found that people had been asked for 'three wishes', we found one person had asked for a meal out, fish and chips, and a meal with a friend. Staff had helped to arrange these. Wireless internet access was being installed in the home at the time of the inspection. Staff told us this would enable people to contact relatives via computer video link [Skype] to help people maintain contact should they wish to do so in this way.

One relative told us, "[Relative] has been out on day trips, and they had an Elvis impersonator in the other week." Another relative told us, their relation was previously bored but some new activities were available. They said, "Activities offered were never what they wanted to do. They are now enjoying armchair activities and sensory sessions. The armchair session has nice meditation at the end. They enjoy being part of a group

[relation] feels like they have friends they are doing something with." A person living in the home told us, "There are activities. What I do is my choice; they do ask me if I want to join in." Other people told us, "The activities person is off and the staff are trying but it isn't working well" and, "There don't seem to be as many trips as there were."

We recommend that satisfaction with activities is monitored in light of mixed feedback from people.

A complaints procedure was in place. People told us they knew how to make a complaint if they needed to. The procedure was available to people and we saw that complaints were dealt with in line with the policy. A number of compliments had been received regarding the care provided and the friendship and kindness staff had shown to people.

Good

Is the service well-led?

Our findings

A new registered manager was in post and the service had been bought by a new care provider in January 2017. Staff were in the process of changing over to the systems and procedures of the new care provider. A relative told us, "The actual transition information we have had has been very good." This meant they felt informed about the changes happening in the home. Staff told us the changes were slightly unsettling but that morale remained good. One staff member told us, "[Manager] is upbeat and wants us all to do well and move forward, I've seen managers come and go, I can see she's committed and passionate about what she does." A visiting professional who had not met the registered manager was complimentary about the deputy manager and told us, "The deputy manager is very good, they're personable, approachable and caring."

The registered manager carried out regular audits. For example, care records were audited and they were aware of the shortfalls we found in some of the older care plans, and a plan was in place to rectify this. A daily 'flash' meeting was held. We observed one which included the registered manager, heads of department including cook, maintenance staff, nurse, senior carer and housekeeper for example. Each gave feedback about any issues that day including general or clinical issues relating to individual people. This meant the manager was updated on a daily basis and was aware of what was happening in the service.
A 'Resident of the day' audit was carried out. This meant that all aspects of the person's care including care plans, medicines, and bedroom facilities were quality checked.

Regular meetings were held with people relatives and staff, and satisfaction surveys were used by the provider to obtain people's views although these had not been carried out at the time of the inspection due to the transition.

The registered manager was aware of the requirements to submit notifications to CQC relating to particular events. They told us they felt well supported by the provider and through regular contact with a regional manager.

Efforts of staff were recognised by the provider and 'Kindness Awards' were awarded in recognition to individual staff. The ones we saw recognised individual staff members for; 'Demonstrating how much care means to them, going above and beyond in their role. To maintain well-being and activities for all residents in a kind and caring manner.'