Beeshaw Care Limited

The Meadows

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was announced 24 hours' prior to our visit, as it is a small home and we wanted to ensure that someone would be available to speak with us. This was the first comprehensive inspection carried out of this service which was registered with the Care Quality Commission (CQC) in June 2017.

The Meadows 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.

The care home accommodates up to 6 people in one adapted building. At the time of our inspection 3 people were living in the home.

The Meadows provided accommodation, care and rehabilitation to adults who have neurological difficulties such as acquired brain injury. The home had communal areas such as a kitchen and lounge, and people were accommodated in their own rooms, each with an en-suite shower or bathroom

There was a registered manager working in the service. 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.

People were supported by a suitable number of staff who understood how to keep them safe, and staff were recruited safely. Risks to people were assessed and mitigated, including those associated with the environment they lived in as well as their own health needs. Staff administered and supervised medicines safely, and people received these as prescribed. The home was clean and there were infection control processes in place.

People's needs were thoroughly assessed prior to moving into the home. The staff continued to work effectively with other teams to ensure people received consistent care. Staff received training relevant to their roles, including the provider's mandatory training as well as training specific to some people's needs. They also received supervision from the management team. Staff supported people to drink enough and to eat a balanced diet, and to access healthcare from other professionals as needed.

People lived in a homely environment and garden which was adapted to their needs. Staff knew about people's mental capacity and understood how to support people to make decisions. There were also appropriate healthcare professionals involved in making best interests decisions for some people.

There were caring and supportive relationships between staff and people. Staff adapted their communication according to people's needs. Privacy and dignity was respected at all times, and people and relatives were involved in their care as much as possible.

Care records were in place for people living in the home, and these contained individualised guidance for staff about how to support people. People were able to go out into the local community if they wanted, and participate in activities, as well as do activities in the home with staff.

People and relatives felt they could raise any concerns with staff, and a complaints system was in place.

There was good leadership in place and staff felt happy in their roles. There were quality assurance systems in place which contributed to assessing, monitoring, and improving the service provided.

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.

There were systems in place to keep people safe and manage risks associated with their care.

There were enough staff to keep people safe and they understood how to keep people safe.

Medicines were administered as they had been prescribed.

Is the service effective?

Good

The service was effective.

Staff were competent and received training relevant to their roles.

People were supported to eat and drink enough to meet their needs.

Staff understood people's mental capacity and supported them to make decisions.

The organisation supported people to access healthcare an worked with professionals to achieve consistent care.

Is the service caring?

Good

The service was caring.

Staff had built positive relationships with people and were kind, caring and compassionate.

Privacy and dignity was respected and staff encouraged people to maintain their independence.

People and their families were involved in their care as much as possible.

Is the service responsive?

Good

The service was responsive.

The service supported people to participate in activities which reflected their interests, both within the home and the local community.

Care plans reflected people's needs and contained guidance for staff on meeting people's needs.

Is the service well-led?

Good

The service was well-led.

There was good leadership and teamwork in place and the management team were approachable and accessible. The registered manager was aware of their responsibilities.

There were systems in place to monitor, assess and improve the service.

The Meadows

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 24 July 2018 and was announced. We gave the service 24 hours' notice of the inspection because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. The inspection was carried out by one inspector.

Before the inspection, we reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law.

During the inspection, we spoke with one relative and sought feedback from five healthcare professionals, which we received from one. We also spoke with the director, the registered manager, the deputy manager and two support workers including a new staff member. We looked at two care records, as well as the Medicines Administration Records (MARs). We also looked at records relating to the management of the service, such as audits and rotas. We were not able to gain verbal feedback from people using the service, due to communication needs and some being being unavailable. When we were in the home we observed some interactions between staff and people.

Good

Is the service safe?

Our findings

The relative we spoke with assured us that they felt their family member was safe and well-looked after in the home. Staff knew how to protect people from harm and had received relevant training. Staff were able to tell us what different types of abuse there were and who they would report any concerns to should they have any.

People's care records contained individual risk assessments, which included information about people's behaviour, health conditions, eating, drinking and mobility. They contained guidance for staff, who demonstrated good knowledge of risks to people and how these were managed. Risks associated with the environment were managed properly, for example water, electricity and fire. Each person had a PEEP (Personal Evacuation Plan) and the service had completed fire drills regularly to ensure that staff knew what to do in the event of a fire. There were safety mechanisms in place such as window restrictors throughout the communal areas of the home and people's rooms.

There were enough staff to keep people safe and ensure there was time to spend meaningfully with people. The relative we spoke with, and staff confirmed that there were enough staff, and this was reflected by the staff rota which we looked at. The registered manager explained that the service used their own staff to cover shifts in the event of staff absence, and they were registered with an agency as part of a contingency plan, but these were not used regularly.

There were systems in place to ensure that only people deemed suitable, in line with the provider's guidance were working in the home. The recruitment policies and induction processes contributed to promoting people's safety. Staff confirmed that they had not been allowed to commence work alone with the people using the service until relevant checks, such as a DBS (Disclosure and Barring Services) check had been completed. They also confirmed that references had been requested from them, and their knowledge and any gaps in employment, were discussed at their interview.

The people living in the home received support to take their medicines, which ranged from full administration to supervision and prompting people, to empower them to take their own medicines eventually. We checked the MARs, and further records relating to people's medicines. We saw that staff signed the record when medicines had been administered, and that people received their medicines as prescribed. There were protocols in place for PRN (as required) medicines which guided staff on how and when to administer these. One staff member explained how they would administer one medicine, and said they would always check they had followed the protocol and request advice from the management team.

Medicines were stored at a safe temperature, which was checked regularly. We saw that not all medicines were dated when opened, for example there was some nasal spray which had not been dated when opened. This meant there was a risk that these medicines could become out of date without staff realising and no longer be as effective. This had been identified on the recent medicines audit. We discussed the option of adding a column to the audit so that an outstanding task could be ticked off to show as completed to ensure this happened in a timely manner. We saw that some topical creams were dated when opened, so

staff could monitor whether they were safe for use.

Medicines were stored in a locked cabinet securely, however there was one medicines which was not stored according to guidelines, as it was associated with higher risk. We discussed this with the director and they ensured it was placed into a secondary locked cabinet immediately following our inspection.

The home was clean and tidy, and there were systems and equipment such as gloves, available and in place to prevent the spread of infection as much as possible. The home had also received a five star food hygiene rating, and had effective systems in place to support people safely with food preparation.

The home had not had any safety related incidents recently, however they explained how they worked with external organisations to ensure people were kept safe. For example, with a psychiatrist when there was a risk associated with people's behaviours.

Good

Is the service effective?

Our findings

Prior to living in the service, people's needs were fully assessed so that the service could ensure they were prepared and fully able to meet a person's needs. This included gathering details of the persons needs including support with manual handling, personal care, health conditions and emotional and mental health needs. The registered manager demonstrated how they had participated in multidisciplinary meetings, liaised with relevant healthcare professionals and family members, and assessed people thoroughly prior to coming into the home. A healthcare professional also told us the service had completed a thorough assessment for one person in order to support their move.

The relative we spoke with told us they had no concerns about the competence of the staff. We observed that staff supported people effectively. New staff received inductions which were individualised according to their confidence and experience. One new staff member we spoke with confirmed they had shadowed a more experienced member of staff for two weeks in each of the providers' homes, for a total of six weeks. They said this allowed them to understand people's needs and understand the role properly before working independently with people. Inductions also included training and supervision.

Staff we spoke with told us they felt the training was effective, and they received enough. Most of the training they received was carried out in-house in a classroom session. The training which the provider had deemed mandatory included manual handling, equality and diversity, and medicines management. Staff also received specialist training according to people's needs, such as epilepsy, and PEG (Percutaneous endoscopic gastrostomy) tube feeding, which is when a tube is passed through the abdominal wall to the stomach. There were also regular competency checks to ensure staff administered medicines according to their training. We looked at records confirming when training had been carried out, some training updates were outstanding due to an unexpected absence of a member of the management team, so the service was planning the outstanding training for the Autumn. However, care and management staff assured us that they felt they were competent and knowledgeable in their roles. Staff were supported by the provider to undertake further qualifications such as the care certificate to develop their skills for their roles. Staff also received supervisions regularly where they had an opportunity to discuss their role with a member of the management team.

Staff supported people to eat a varied, balanced and healthy diet according to their needs. For example, if people followed a special diet. Staff also supported some people to make their own meals in the kitchen, and people could choose what to have. Although there was a menu planned for the week, this was flexible and people could choose something else if they wished. People were also supported to drink enough, and the registered manager had ensured this was recorded for everyone using the service following a period of very warm weather.

The staff worked closely with other organisations and professionals, for example people's social workers, GPs and consultants to ensure people received proper treatment and that their quality of life was enhanced. In supporting people to move between services, the staff gave an example where they had worked closely with staff from a different organisation, within the home when a new person moved in. This meant that the

staff who had previously worked with the person, taught the staff at the Meadows exactly how to support the person to ensure their transition was as consistent as possible. We sought feedback from a healthcare professional who was involved with this, and they informed us that the staff were keen to learn, and followed their recommendations. The staff also made sure that in the event of a hospital admission, relevant information was sent with people. People were supported to attend appointments when they needed, and access healthcare as necessary.

The environment within the home was light and homely with appropriate even flooring. People's rooms had big windows and fitted furniture such as wardrobes. Where possible people had chosen their own items such as bedding, and how they wanted to have their rooms arranged. There was a big kitchen, and there were signs to support people to know where to do food preparation, and for the fridges and freezers.

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 interest and as least restrictive as possible. We saw that there were some decision-specific mental capacity assessments carried out, for example in relation to supporting people with GP visits. However, we found that there were not always decision-specific capacity assessments for people to ascertain their management of finances, and potential to self-medicate or to return home. We discussed these with the registered manager who told us they would ensure these were carried out. This would ensure that the person is being supported to uphold their rights. We saw that the staff had worked closely with other healthcare professionals in relation to managing people's capacity, and had a good understanding of individual's mental capacity. Where people had variable or limited capacity, the staff supported people by making decisions in their best interests, and involving family and healthcare professionals where appropriate.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes are called 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 had applied for DoLS for some people living in the home following the appropriate mental capacity assessments. We found that staff supported people to make decisions where they could and were well-informed about these. As some people had variable capacity, the DoLS applications were explained and discussed with people.

Good

Is the service caring?

Our findings

The relative we spoke with described the staff as, "Kind". They said they were always welcomed into the home by staff, who were approachable. One member of staff demonstrated their empathy, saying, "I always try and put myself, how I would feel in that person's position." Staff and people had built trusting therapeutic relationships, and staff adapted their communication to suit people's needs, so that they were able to communicate as much as possible. This included when people were not able to communicate verbally, and staff demonstrated that they knew the people's communication needs well. This included an understanding of what different kinds of behaviour usually meant for certain people, in terms of how they were feeling. Feedback gained from a healthcare professional stated that the staff understood people's communication needs.

We observed that the staff had a caring approach towards people, and when they spoke with people's relatives. All the staff we spoke with about personal care told us they talked to the person throughout; one member of staff said, "We always explain what we're going to do." This was reiterated by another staff member we spoke with. Staff also said they found working with the people in the home rewarding. They knew people well, and gave examples of when they used humour with certain people because they knew they enjoyed this and engaged well.

People were consulted in a sensitive manner about the care they received. Where people disagreed with staff, these situations were handled sensitively and involved relevant professionals. People also had access to independent advocates if needed. The relative we spoke with said they talked to staff regularly, and the management team were available on the phone if they were not in the home when they visited. They said they were involved with their family member's care as much as possible, and communicated with both the staff, and other healthcare professionals involved in the service. We saw evidence of relative's involvement for other people living in the home, for example, the staff were working with another person and their family to support them to go on home visits.

The relative we spoke with confirmed to us that staff always respected their family member's dignity and privacy, saying "[Staff] always close the door." They said staff also ensured they had time alone together if they wished, when visiting the home. They told us, and staff confirmed, that personal care was always carried out with dignity, and behind closed doors and curtains. Staff also demonstrated an awareness of the importance of confidentiality and respected this.

The home worked to rehabilitate people and encourage their independence as much as possible. Two staff members explained to us how they prompted and encouraged people to do as much as they could for themselves, and supported them only when needed, whether physically or through supporting people to make a decision. People were empowered to go out into the community if they were able and wished to. Staff also supported people to walk, prepare meals and clean their own rooms as far as possible in order to learn and maintain their independence.

Good

Is the service responsive?

Our findings

People received care that was responsive to their own individual needs. Staff gave us examples of how people maintained choice and control, for example choosing when they wanted to get up, go to bed, or have a shower or bath. Where people were not able to communicate verbally, they knew their body language and behaviours well. This meant that staff were able to meet their needs as much as possible, by ascertaining whether they were comfortable or not. Care plans were in place to guide staff on how to meet people's needs, for example, with regards to their mobility, eating and drinking, emotional wellbeing and supporting people with activities and personal care. The care records included referrals and letters from other healthcare professionals involved in people's care. Care records were updated whenever people's needs changed and were more formally reviewed on a regular basis.

People were supported to participate in various activities both in the home and going out into the community to engage with sports and activities. On the day of our inspection visit one person had gone to a local activities club. There was a pool car available for the home which meant that people were able to go out regularly. For some people, staff supported them to go for a walk, go in the garden with a football or participate in crafts or baking in the home. Where people wanted to plan an activity or had an aspiration to do something specific, staff supported them with this.

There was a case manager employed, and the registered manager told us that the main part of their role was to engage with people living in the provider's homes to ensure they were happy with the care they received. They held regular discussions with people and ensured they had everything they needed. This role was to act as a key worker to all of the people living in the provider's homes, and the registered manager told us this worked well.

The relative we spoke with told us they felt the management team and all of the staff were approachable and they felt comfortable to raise any concerns or complaints if they needed to. The service had received some complaints from a person living there, and they had liaised with the appropriate professionals involved, and resolved these as far as possible. There was a system for making complaints in place.

People's care records contained information which would be used to ensure people had their preferences met towards the end of their lives, however there was not a need for palliative care in the home at the time of our inspection visit. Some staff had received training in end of life care, and the registered manager ensured that appropriate professionals, including GPs, were also involved with people's care throughout their time living in the home.

Good

Is the service well-led?

Our findings

There was a positive culture amongst the staff working in the home, and the staff told us they were happy working for the provider, and enjoyed their work and worked well as a team. Without exception, the staff we spoke with said that they felt well-supported by the management team and the provider's organisation. The registered manager or the deputy manager was available to support staff if needed and someone was always on call in the case of an emergency or extra support needed. The healthcare professional who we received feedback from said they had found the registered manager, and the staff, contactable and responsive.

Staff were motivated and they received incentives for going the extra mile or carrying out additional work. They worked flexibly according to the changing needs of people living in the home, for example altering their hours if needed.

Staff performance was monitored to ensure they were supporting people according to the provider's ethos, as well as adhering to health and safety and meeting people's needs. Performance management systems were in place when needed to ensure that staff were working to the expected standards. This meant that the service provided was monitored so that problems would be picked up and acted upon and people were working to a high standard.

The registered manager had been in post since the home opened in July 2017, and had been supported by the director and a deputy manager. The registered manager was aware of their responsibilities to report certain incidents or information to CQC and other authorities when required.

There were quality assurance systems in place such as audits for the medicines and infection control. There were also questionnaires to gain feedback from relatives, which had not yet been completed but planned to go out in the next few weeks. There were also regular informal discussions with family members and people living in the home. The director and the registered manager explained that feedback would be used to improve the service. The deputy manager explained that as the home was new, they were focussing on establishing the location and service, and admitting people to live in the home.

The registered manager worked closely with other organisations, both during people's transfer from other services and throughout their care. They also worked with other organisations to support people to engage in the local community and ensure consistent care and support.