Dr Brian Cheung

Beech Court Nursing Home

Inspection report

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Ratings

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

Overall summary

We carried out this unannounced inspection on 16 December 2014.

Beech Court Nursing Home provides nursing care for people over the age of 65. The home can accommodate up to 26 people and at the time of our visit 12 people were using the service, some of whom were living with dementia.

We last inspected in May 2014 we found two breaches of regulations in relation to records, the management of medicines and quality assurance systems of the provider. At the inspection in December 2014 we found the provider had taken action to rectify these concerns.

There wasn't a registered manager in post at the service because the provider is not required to have one. However, the provider had recruited a manager who they planned to support through the registration process. A registered manager is a person who has registered with

Summary of findings

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.

Areas of the home were undergoing maintenance at the time of our inspection. While health and safety notices had been put into place, these were not always being followed. People may not have been able to be evacuated safely and effectively. People's mobility equipment was not always stored in a way which kept it clean and safe to use.

People were not always protected from the risks of pressure area damage. Pressure relieving equipment was not always set up in accordance with people's needs and staff had limited guidance on how to use this equipment.

Staff had knowledge of safeguarding processes, the Mental Capacity Act 2005 (MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time) and Deprivation of Liberty Safeguards. The service ensured where people could not make specific decisions, best interest decisions were conducted and respected.

People received their medicines when they needed them and as prescribed. The home had audits in place to identify any concerns and ensure people were protected and lessons were learnt from concerns.

People enjoyed the relationships they had with staff and staff knew people, their needs and preferences. People were cared for by skilled care and nursing staff. People told us they were treated with dignity and respect and staff supported people with kindness and patience.

People's needs were documented and these were reviewed and updated monthly or more frequently if needed. The management team acted upon feedback from people and their relatives. Feedback was used to inform changes to the service people received.

A new management team had been recruited by the provider. There were clear goals about developing the service people received. However, these plans were still being developed and we could not see the full impact of these audits.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

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 was not always safe. Arrangements for the evacuation of people in the event of a fire were not safe. People's care plans did not always contain information around pressure area care. Pressure relieving equipment was not always effectively used.

People told us they were safe. Staff had knowledge of safeguarding adults and were confident in raising concerns. The service raised safeguarding alerts when concerns were identified.

People's medicines were stored and administered safely.

Requires Improvement

Is the service effective?

The service was effective. People's care plans did not always contain information around pressure area care. Pressure relieving equipment was not always effectively used.

Staff had received training to meet people's needs. There was a clear plan of training and support to ensure staff could meet people's needs.

People told us they had plenty of food and drink. Staff had good knowledge of people's dietary needs.

The deputy manager and staff had knowledge around the legal framework when supporting people to make decisions and making decisions in people's best interests'.

Good

Is the service caring?

The service was caring. People were involved in planning their care and where possible made decisions regarding their care.

Staff were kind and compassionate. People were cared for by staff who respected their individuality.

Staff knew the people they cared for and provided support to make people feel comfortable.

Good

Is the service responsive?

The service was responsive. People's care plans were personalised and contained information about their likes and dislikes.

People's views on the home were sought, and people had access to activities and support from care staff.

Good

Summary of findings

Is the service well-led?

The service was not always well led. The provider had recruited a new management team, who were developing systems to ensure the quality of service. These systems were not fully developed at the time of our inspection.

Medicine audits were effective and enabled staff to identify concerns and ensure people were protected.

The provider had a clear plan to develop the service and staff were being supported to make changes to the service.

Requires Improvement

Beech Court 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.

This inspection took place on 16 December 2014 and was unannounced. The inspection team consisted of two inspectors.

Before the visit we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. This enables us to ensure we were addressing potential areas of concern. We spoke with local authority safeguarding adults and contracts teams and sought the views of two healthcare professionals.

We spoke with six of the 12 people who were living at Beech Court Nursing Home. Not everyone we met was able to tell us their experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

In addition we spoke with one registered nurse, two care workers, the chef, the deputy manager and provider. We looked around the home and observed the way staff interacted with people.

We looked at five people's care records including their medicine records and at a range of records about how the home was managed. We reviewed feedback from people who had used the service and a range of other audits.

Requires Improvement

Is the service safe?

Our findings

At our inspection in May 2014 we found people did not always receive their medicines when they needed this was a breach of regulation 13. Following the May 2014 inspection the provider sent us an action plan which detailed how they would use medicine audits and staff training to ensure people received their medicines. At this inspection we found action had been taken to bring the service up to the required standard.

People told us they received their medicines when they needed them. Medicine records were fully completed with details of when people received medicines, the amount and the time the medicine was administered. One person told us how they received pain relief when they needed. They said; "I get aches. I tell the staff and they help me."

All medicines were securely stored in line with current and relevant regulations and guidance. People's medicine records accurately reflected the medicine in stock for each person. Medicine stocks were checked monthly by a senior member of staff. These checks showed staff monitored stock to ensure medicines were not taken inappropriately and people received their medicines as prescribed.

During our visit, building and maintenance work was being carried out at the home. Areas of the home were no longer being used by people and staff. These areas were clearly marked by health and safety notices. Health and safety notices stated rooms being maintained should be locked due to the risk of injury, however we found this guidance was not always being followed. A temporary fire exit was also in place so people and staff could leave the building if there was an emergency. This route was not clear and was not level. This was a trip hazard which posed a risk and staff may struggle to evacuate people who would need assistance. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Four people were cared for on pressure relieving mattresses to reduce the risk of developing pressure ulcers. These mattresses were set at settings which were dependent on people's weight so that people were protected from damage to their skin. For three of the people, we found the mattresses were not at the correct setting and placed them at risk of developing pressure ulcers. We discussed this concern with a nurse, who told us, "each mattress setting, depends of the person's weight. I will check it." We looked at the care plan for each person and saw clear plans were in place for staff to assist each person, but there were no records about how to ensure people's equipment was set to their needs. No one had pressure sores at the time of our inspection, however because equipment was not always set correctly, people were being placed at risk. This was a breach of Regulation 16 (1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Equipment people used to assist them with their mobility. One person's wheelchair was being stored in a bathroom which was not being used due to maintenance work. The wheelchair was covered in dust from the building work and had not been kept clean. There was no record to show if this piece of equipment was being regularly maintained. If the person required their wheelchair, it would not be immediately available. We discussed this with the deputy manager, who assured us the wheelchair would be cleaned and maintained.

Various items of equipment used to support people such as hoists and specialised baths, were checked by a service engineer every six months to ensure they were still safe to use. Staff we spoke with told us they would not use any equipment if there was a fault.

The service had systems in place to manage risks with the least restriction on people's freedom and choice. For example, staff had identified that one person's mobility had decreased. This person liked to have a shower, however due to their restricted mobility staff could not safely carry this out. The manager had made a request to local healthcare professionals for specialist equipment. While staff were waiting for this equipment, they ensured the person received a bed bath as they were unable to have a shower. Care records showed the person and their family were happy with the action taken.

People said they were safe. Comments included: "I'm safe here"; "I'm safe, this is my home", "I've no concerns, I'm good here."

People told us there were enough staff on duty, and they always had assistance when they needed it. People told us the staff came quickly if they needed assistance. We saw when people needed assistance staff; staff responded and took time to meet people's needs.

Requires Improvement

Is the service safe?

Two staff members said while there was enough staff to meet people's needs, they felt there had not always been enough care staff employed by the provider, they felt this often left them under pressure to work longer hours. We spoke with the provider who told us recruitment had been on going to ensure there were enough staff to meet the needs of people and ensure staff were not over worked. They told us they had taken this action due to concerns raised by staff. All staff told us the situation was improving. Rotas showed us the provider had ensured there were always enough staff on duty in accordance with people's needs.

Staff were knowledgeable about types of abuse, signs of possible abuse, which included neglect, and their responsibility to report any concerns promptly. Staff told us they would document concerns and report them to the nurse in charge, the manager or the provider. One staff member said, "If I had any concerns I'd go to the nurse or the provider." Another staff member added that, if they were unhappy with the manager's or provider's response, "I'm aware I can go to safeguarding if needed." Staff told us they had received safeguarding adults training and were aware of the local authority safeguarding team and its role. Training records showed staff had completed safeguarding adults training.

The provider had worked with local authority safeguarding team to ensure people were protected from abuse. For example, they had raised concerns about one person missing their prescribed medicine and taken action to ensure the person was protected.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and disclosure and barring checks (criminal record checks) to ensure staff were of good character. In addition staff told us they received induction training and a period of shadowing of more experienced staff.

Good

Is the service effective?

Our findings

At our last inspection in May 2014, we found staff in the home did not always receive the training they needed to meet people's needs which was a breach of regulation 23(1)(a). Following the May 2014 inspection, the provider submitted an action plan which detailed how they would ensure staff had appropriate training and supervision. At this inspection we found action had been taken.

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People spoke positively about the home and the care they received. People told us: "The staff are excellent. I've never been so well looked after"; "I always eat and sleep well. That's what's important to me", "It's a quiet home, but I wouldn't change anything" and "The staff are good."

Staff told us they had a range of training to meet people's needs and keep them safe including safeguarding adults, moving and handling and fire safety. Nursing staff had completed training about medicines management, tissue viability and catheter care. Staff spoke positively about the training they received. Staff also told us future training was being organised to ensure they had the skills to enable them to continue to meet people's needs. One member of staff said, "we've had lots of training in the last few months, fire safety, moving and handling. We do worksheets after training to show what we've learnt," and "there is additional training available, I'm doing a dementia qualification."

Staff received frequent one to one supervision meetings and an annual appraisal with their line manager. These meetings were used to discuss training needs and any concerns or performance issues. We saw records of supervisions which included questionnaires about training staff had recently received. The manager used these questionnaires to ensure staff had knowledge of the training. Staff were also asked for their views on training and any concerns they had working in the home.

Staff told us they had completed training about the Mental Capacity Act 2005 and were aware of its principles, such as decisions having to be made in the best interest of a person who lacked capacity. Staff told us how they supported people to make day to day decisions, and how they promoted people's choice. A nurse we spoke with about consent said they would respect the person's wishes if they declined medication.

Staff had sought the support of an Independent Mental Capacity Advocate to ensure a decision regarding one person's care was in their best interest. Staff had identified the person was at risk of falling out of bed. A mental capacity assessment was carried out for the use of bed rails because the person did not have capacity to make this specific decision. A best interest meeting was conducted, and it was agreed it was in the best interests of the person for bed rails to be in place.

This person had a Deprivation of Liberty Safeguards (DoLS) authorisation agreed by the local authority. DoLS is a framework that allows a person who lacks capacity to be deprived of their liberty where it is deemed to be in their best interests or for their own safety. Staff had the information they needed to care for the person in the least restrictive way.

Staff had identified one person who was declining personal care. Staff had recorded this and sought the views of local healthcare professionals, the person's GP and family. A best interest meeting was held and a clear plan was in place for staff to assist the person whilst respecting their choice to decline care. As part of this meeting, covert medicines had been authorised. We spoke with the nurse who understood the need for covert medicines and the importance of the family's involvement.

People told us they had plenty to drink. People had juice or water in their rooms and they told us these drinks were changed daily or when they wished. Staff encouraged people to drink throughout our inspection. Where people were at risk of dehydration staff recorded all fluids they had given the person. Staff had a clear understanding of how much fluid each person needed to meet their needs and protect them from risk.

Kitchen staff told us one person had a pureed diet and also needed thickened fluids as they were at risk of choking. We saw this person received a pureed meal for lunch and all their drinks were thickened. We spoke with three care

Good

Is the service effective?

workers who had good knowledge of how to prepare fluids for people who were at risk of choking. One staff member said, “we are given clear directions on how to thicken fluids. Nurses take the time to show us if we need.”

Where people were at risk of malnutrition, food supplements were used to ensure people’s nutritional needs were met. Staff used fortified drinks such as milkshakes to meet people’s needs and protect them from malnutrition. People told us they had choice about their meals. One person said they enjoyed the cooked breakfast, they also said, “I have plenty to eat and drink. The food is good and I get choice with meals and snacks.” Another person told us, “The chef is particularly good. You get what you want.”

A range of professionals were involved in assessing, planning, implementing and evaluating people’s care and treatment. These included GP, psychiatrist, district nurses, community mental health nurse, speech and language therapist, and other professionals from the Care Home Support Team. One healthcare professional told us staff sought their advice when necessary. They also said when advice was provided, this was followed. People had no concerns about access to doctors and told us they had the support they needed.

Good

Is the service caring?

Our findings

People told us they were treated with kindness and compassion. Comments included, “I’ve never been so well looked after”, “I get a lot of help. I’m very well looked after”, “They certainly look after one well.”

One person required support from staff due to health issues with their vision. We saw one staff member take time to support the person with their lunch time meal. The staff member talked with the person and used touch to let the person know where their lunch was. They asked if the person required any further assistance. The person thanked the care worker and told us they enjoyed their lunch. We spoke with this person, and they spoke positively about the support they received from staff.

Staff spent time talking with people and supported them to make choices. We observed one staff member offer people a choice of drink. They took time to ensure each person was okay and respected each person as an individual. The staff member maintained eye contact and each person smiled and talked to the staff member.

We observed two care staff spending time talking with people during our visit. Staff and people talked about their day, families and lives. Everyone was happy and enjoyed the discussion. One staff member told us, “we have time to spend with people, to talk about them and they ask about us. It’s very relaxed and people enjoy this.” Staff told us they were supported by the provider and manager to develop relationships with people. Everyone we spoke with talked positively about the time they spent with staff, one person said, “it’s a small home. I like it, it’s our home and the staff are like family.”

People were involved in planning their care wherever possible. One person had told staff their preferences of care and how they wished to spend their time at the home, which included sitting with a lifelong friend. We saw this person’s choices were respected. Another person had made a clear plan for their end of life with staff. We spoke with this person and they told us, “I decided not to DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation)” and gave clear reasons for their decision.

Staff demonstrated a good understanding of how supporting people to be as independent as possible helped them to feel valued and empowered. One care worker told us "We try and promote choice and involve people as much as we can. One person with encouragement can do a lot by themselves.” One person told us how staff supported and encouraged them with personal care, they told us, “They don’t do anything I can do for myself. They respect me and only assist if I ask.”

Staff told us how they ensured people received their care in private and respected their dignity. One person told us that the care worker “knocked on the door” and made sure they were “covered” during personal care. One care worker said "if we provide personal care, we do this in private. We make sure people’s dignity is respected.”

Staff knew the people they cared for. Staff told us about people’s likes and dislikes and what was important to each person. This information was also recorded in people’s care plans. Staff respected people’s choices. One person liked to have a cooked breakfast most mornings. This person said, “I always get what I ask for, I’m given choice and staff never presume.”

Good

Is the service responsive?

Our findings

People told us they were involved in planning their care. One person told us how they discussed their care plan with staff and spoke positively about how staff involved them. They said, "I have my say, I recommend it here."

Care plans included information relating to people's social and healthcare needs. They were written with clear instructions for staff about how care should be delivered. They also included people's preferred routines for getting up and going to bed, what they had enjoyed doing in the past, work and social life as well as family and friends. The records showed where people and their relatives had been involved in planning their care and documenting their preferences. One person had a clear plan around their emotional needs, which showed they liked the comfort of holding a stuffed toy.

People's care plans and risk assessments were reviewed monthly and where changes were identified, the plans were corrected to reflect the person's needs. On-going care notes were completed on a daily basis, and provided clear information on how the person was and what assistance care staff provided. People's care plans provided information staff needed to meet people's needs. For example, one person's care plan gave instruction to staff on how to involve them in their personal care, including what the person could do for themselves.

People told us there were activities offered at the home. People told us these activities were based on their preferences. One person said "people come in to help with handicrafts". Care staff led some activities like bingo in the afternoons. People also said the local church held a weekly service at the home. Staff said they had been taking training to provide specific activities and one to one activities for people in the home. One staff member said, "people have input into activities, we ask them what they want to do." One person told us, "I don't want to do activities; I like to sit and talk to the girls (carers), that's what I like." The provider informed us they were looking to recruit an activity coordinator, and discussed the importance of providing more activities when there are more people living in the home.

Care staff told us they had time to spend with people who chose to stay in their own rooms. Care staff would talk about people's life and ensure they were happy. One person said, "they tell me when things are happening, however I sometimes like my own company." One person was unable to leave their room; care staff ensured music was playing for the person. The person's preferences around music were recorded in their care plan.

There was guidance on how to make a complaint displayed in the home in an accessible location for people and their visitors. We looked at the complaints file and saw complaints had been dealt with in line with the provider's policy and people were happy with the outcomes. One person told us that "If we were unhappy with anything, we'd go to the manager." Another person said that the provider had said "If there's anything you don't like" to tell them.

In November 2014 the manager and the provider conducted a survey of people's views about the home. The survey identified people felt some staff were not always approachable. We saw the provider had implemented an action plan, which detailed the training and support they would provide to all staff to ensure people felt comfortable with staff. Training and supervision records showed this was on-going. People told us action had been taken.

Requires Improvement

Is the service well-led?

Our findings

The manager had implemented weekly risk reports to show concerns to the provider. These included changes in people's needs, concerns around people's health and well-being and any complaints. The reports enabled the manager and provided to discuss concerns and make changes to service as necessary. While these reports had developed, they were not being completed consistently and therefore concerns were not always being acted on to improve the service.

While a number of systems had recently been put in place, there was limited information to show the impact these audits had on developing and improving the service people received. We could not identify the impact on people receiving a service. The manager with the support of the provider had a plan to develop and maintain clear systems to enable them to identify any concerns at the home.

People and staff spoke positively about the provider and the recent changes to the management of Beech Court Nursing Home. The provider had recruited a manager and deputy manager, to help develop the home. The deputy manager was a registered nurse, who was aiming to provide clinical support to staff in the home. One person said, "the new manager is good, they spend time getting to know us." One staff member said, "the provider always listens to us, they've really made sure things have improved." Another member of staff told us, "We've got a management team now, and we're looking to grow. If you go the deputy manager you know they'll sort any problem."

The manager had started to observe staff competency. Records of nurse's competency around medicines and clinical skills had been conducted. At the time of our visit not all care staff had received a clinical observation (an observation to see if nursing staff are working as required). A clear plan was in place for these observations to be completed by the end of December.

The provider had a clear plan to develop a caring culture and ensure people received a safe and effective service at the home. This included the recruitment of a management team, with support from external professionals, as well as ensuring staff had the training they needed to meet people's needs. Staff we spoke with were aware of the changes and were optimistic about the development of the home. All staff were aware of the providers aim to provide a caring culture. One staff member told us, "The provider wants to provide good care, we all do, things are really improving."

A range of audits had been conducted around care plans, falls and staff competency. We saw a record of these audits, which identified concerns and actions which had been taken. For example the audit identified one person's care plan was missing current information. An action was implemented for this file to be updated, which had been completed by staff.

Medicine audits had been conducted following concerns raised at our last inspection. We saw the results of these audits were discussed between nurses, the manager and provider. Audits clearly identified any concerns and enabled the provider to report any medicine concerns to local authority safeguarding. These audits had enabled the service to improve the ordering, storage and disposal of people's prescribed medicines.

Staff were encouraged and supported to make changes within the home. One member of staff had told us how they had been supported to write and make changes to care plans. A nurse told us they had been supported to conduct audits and make changes to the service to ensure people's clinical needs were met.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **How the regulation was not being met: People were not always protected from harm as safety measures in place were not always used Regulation 15 (1)(a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment **How the regulation was not being met: People were not always protected from the risk of pressure sores, as equipment was not always effectively used. Regulation 16(b).**