Rowlandcourt Healthcare Limited

Beechwood House

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

The inspection took place on 29 and 30 August 2018 and was unannounced.

Beechwood House is registered to provide accommodation for persons who require nursing or personal care, for a maximum of 37 people. At the time of the inspection 37 people were living at Beechwood House, many of whom were living with dementia. Accommodation is over three floors, accessed by a lift, and includes shared living areas. There is a large garden to the rear of the home.

Beechwood House 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.

There was a registered manager is post at the time of the inspection. 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.

At the last inspection in September 2016 we found that the provider was in breach of Regulation 12 of the Health Social Care Act 2008 (Regulated Activities) Regulations 2014 because medicines were not managed safely. We asked the provider to complete an action plan to show what they would do and by when to improve the key question of safe to at least good. At this inspection we found that improvements had been made. The service was managing medicines safely, and the provider was no longer breaching the regulation.

Staff were person-centred and treated people with kindness, compassion and respect. People's visitors were welcomed and their privacy and dignity respected. People were supported to remain as independent as possible.

Activities were tailored to the interests and abilities of people. Staff supported people to challenge themselves and celebrated their successes.

End of life care was innovatively supported by the service. The right support for people, their relatives and the staff team had been considered and provided.

People told us they felt safe. Processes in place around safeguarding and the management of falls were followed, and lessons learnt to prevent reoccurrence. Risks to people's safety had been appropriately assessed, and measures to reduce the risk implemented.

There were sufficient staff available to meet people's needs, who had been recruited through safe recruitment processes. Staff were supported to ensure they had the right skills and knowledge to support people.

People were 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.

The registered manager led the service well. Staff told us they were well supported and people and their relatives told us they were involved in decisions about their care and the service.

The service worked in partnership with healthcare and other professionals, to ensure the best support for people.

There was a clear governance framework in place to assist the management team to identify areas for further improvement.

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.

People told us they felt safe.

Medicines were ordered, stored and administered safely.

There were sufficient staff available to meet people's needs.

Risks were identified and assessed, with appropriate measures put into place to reduce risks for people.

Is the service effective?

Good

The service was effective.

Staff had the right knowledge and skills to support people.

People's needs were assessed and care and support offered in line with these assessments.

People were offered choices and their capacity to consent was considered in line with the Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

People were treated with kindness, compassion and respect.

Staff were person-centred.

People's privacy and dignity was respected.

People's independence was promoted.

Is the service responsive?

Good

The service was responsive.

Activities were well thought out, and adapted to people's

interests and abilities. Staff supported people to challenge themselves and celebrated their successes.

The service had focus on the care at the end of people's lives and considered how to support people, their relatives and the staff team.

People and their relatives were involved in the planning and reviewing of their care.

Is the service well-led?

Good

The service was well-led.

The registered manager was very supportive to the staff team.

People, their relatives and others were consulted about the service.

The service works in partnership with other agencies.

There was a clear governance framework in place to allow the service to continually improve.

Beechwood House

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 29 and 30 August 2018 and was unannounced.

The inspection team was made up of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection we talked to seven people using the service and five relatives of people living at the service. We observed activities and a lunchtime. 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 spoke with the registered manager, the deputy manager, the head of care, two care staff and an activity coordinator. We reviewed a variety of records, including care records relating to five people, four staff files and other records relating to the management of the service, such as policies and procedures, accident/incident recording, records relating to the management of medicines and records of audits undertaken. Following the inspection, we spoke with five health and social care professionals for their feedback on the service.

Good

Is the service safe?

Our findings

At the previous inspection, on 26 October 2016, we found that medicines were not always managed safely and that this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The inspection found that records of medicine administration had contained gaps and were not routinely completed by staff. This meant that we could not be certain that people received their medicines as prescribed. Some medicines had been out of stock which meant that people had received a lower dose of medicine than they were prescribed. A small number of liquid medicines had not been dated on opening, meaning they could be stored for longer than recommended by the manufacturer, affecting their effectiveness. Audits of how medicines were managed in the service were completed but had not identified all errors. At this inspection, we found that the management of medicines had improved, and there was no longer a breach of regulation.

Medicines were ordered, stored, administered and disposed of safely. Staff received training about medicines and their competency to administer medicines was regularly assessed. People told us they received their medicines at the right time. Individual protocols were in place for the administration of 'as required' medicines. These described how the staff could identify when the use of these medicines would be appropriate. For example, when people were prescribed medicines for anxiety, the protocol included information on how the person would present as anxious. Dates of opening were recorded for liquid medicines and creams. The date of opening is important as a medicine can lose its effectiveness if stored for longer than recommended by the manufacturer. When people were prescribed courses of antibiotics these were recorded, so that the service could monitor the use and effectiveness of the different types of antibiotics, and give this information to the GP, for those with recurring infections.

Due to their health conditions, some people received their medicines covertly. This had been agreed as a decision in their best interests, with the involvement of their families and health professionals involved in their care. A health and social care professional told us, "They have been very proactive at actioning medication reviews to meet the patient's current needs, and change in presentations." Another told us, "The trained staff are willing to learn and understand any medicines that are prescribed from mental health. I provide information leaflets on medicines that are prescribed and which they are not familiar with. The staff are very quick to contact if there are any concerns or wanting advice or discuss potential side effects. Also, they will alert me if the medicine is not effective or targeting the symptoms that are being exhibited."

Weekly audits of medicines were carried out to ensure appropriate stock levels. This allowed for additional medicine to be ordered, as needed, to ensure that people were given their medicines as prescribed. Medicine administration records were also audited to ensure that people were receiving their medicines correctly.

People and their relatives told us they felt safe. One relative said, "I know [relative] is safe. I'm more relaxed, I trust them." Staff knowledge and the processes in place safeguarded people from abuse. Staff knew how to report any concerns about people's safety or possible abuse. Any concerns were appropriately identified and reported to ensure people's safety. People told us they felt confident in the staff supporting them. One

person said, "They are very good. They are friendly, more like friends than carers."

Sufficient staff were available to meet people's needs. Staff communicated with each other to ensure there were sufficient numbers of staff in certain areas, for example, the lounge. Staff responded to people's needs quickly. A health and social care professional told us, "I have always observed staffing has been more than ample. In the day room area those requiring constant monitoring are receiving it, though not intrusively so." Visitors told us there were enough staff. One relative told us, "I've never thought about it. I think that's the answer; I've never had to think about it."

Recruitment procedures were in place to assess the suitability of prospective staff. These included application forms, references and evidence of being able to work in the UK. A Disclosure and Barring System (DBS) check had also been completed, which identifies if they had a criminal record or were barred from working with children or adults. This meant that the provider had assessed the suitability of the staff they employed.

Risks to people were assessed using recognised tools and ways to reduce the risks considered. For example, when an assessment had identified a person was at high risk of skin breakdown the service had implemented pressure relieving equipment, regular repositioning and monitoring of their food and fluid intake. A health and social care professional told us, "The staff put in risk assessments which are person centred and have an understanding also of positive risk taking. Any risks identified are responded to and acted on accordingly."

Systems were in place to monitor and prevent incidents, such as falls. The registered manager analysed where, when and to whom falls were happening. Measures to reduce the risks in these areas where then identified and implemented. For example, the analysis one month identified that the number of falls at night had increased. The service responded by ensuring there was a member of staff in the lounge and in the walkways. They also did regular checks to ensure people's sensor mats were turned on and that people were regularly checked at night. This reduced the number of falls which happened the following month. From January to July 2018 the number of falls per month had reduced from 16 to 6, due to the analysis and action taken.

People were protected by the prevention and control of infection. People told us that Beechwood House was "very clean and tidy." Staff used personal protective equipment (PPE) and other infection control methods such as hand sanitizer. A health and social care professional told us, "The staff take pride in ensuring that the environment is clean and tidy but homely."

There were plans in place in case of emergency. Each person had an individual evacuation plan and the service carried out regular fire drills. There were checks in place to maintain the safety of the service, such as regular checks on gas, lighting, fire prevention and detection systems and equipment.

Good

Is the service effective?

Our findings

People's needs were identified and assessed. People and their relatives were involved in this, as appropriate. A relative told us, "We were very involved, they asked lots of questions about [the person's] day, likes and dislikes, anything [they] were afraid of." People were involved in their care and their views sought and respected, when people had chosen for information not to be shared with certain others, this was considered, documented and respected.

People received support in line with their care plans. For example, we saw one person become distressed. Staff supported them to calm, explaining that they were safe, and holding their hands. This was in line with the guidance in their care plan.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. Where DoLS had been authorised for people, any conditions to these authorisations were complied with.

Staff were knowledgeable about people's capacity to make decisions, and what support people may need to enable them to make decisions. Staff were clear on whom they would consult, when others held legal authority to make decisions on the person's behalf, such as with a Lasting Power of Attorney.

Staff had the right skills, knowledge and experience to support people. Staff told us they had done training is subjects such as epilepsy, fire safety and specific training to support them with challenging behaviour. People told us, "They always seem to know what to do if the need arises." A relative told us, "They always seem to know exactly what they're doing." A health and social care professional told us, "The staff at Beechwood provide excellent care and really understand the needs of patients with dementia." Staff told us that they were asked about any further training they needed and this was provided. Staff had regular supervision where they could discuss their job roles and development.

New staff received an induction to the service including shadowing experienced member of staff, and then worked through the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.

There were opportunities available for those staff who wished to develop their skills and knowledge to complete a Regulated Qualifications Framework (RQF) in Social Care. An RQF is a work based award that is achieved through assessment and training. To achieve an RQF, candidates must prove that they have the

ability and competence to carry out their job to the required standard.

People were supported to access healthcare services and live healthier lives. Discussions with health and social care professionals were documented clearly. People told us they received healthcare support at the right time. One person said, "You speak to the staff and they call for the doctor." A health and social care professional told us, "I have always found the team to be friendly and welcoming." And, "The nurses have always provided me with clear and accurate assessments. This has frequently shown how patient's conditions have drastically improved since they were admitted to Beechwood. I believe this is due to the excellent care and food!"

People were given choices about what they ate and drank. A relative told us, "They always ask. There's a choice of a couple of things. If [relative] doesn't like them, they'll make something else." People's health needs and their preferences were considered. People were supported to have lunch where they wished. Some people ate in the dining room, some in the lounge and others remained in their bedrooms. A daily menu was clearly displayed in the hallway by the kitchen.

People received the support they needed to eat their meals. Staff providing meal time support explained what the meal was, encouraged people to eat and supported people at the right pace for them. Some people's food and fluid intake was monitored, as required, to help to prevent further health complications.

The premises met the needs of the people. Corridors were wide and there was a lift for those who needed it. People's bedrooms were personalised. For example, some people's bedroom doors were painted with a colour of their choice, to help people orientate. This work was still in progress. One person told us, "They asked people what they would prefer with the doors." One person's relative told us, "They asked about decoration of the rooms. [They] got exactly what [they] wanted, it was very good."

Signage was displayed around the home to help people move around the service independently. A small lounge included a mural of a local attraction. We saw people use this space with their visitors and when the hairdresser visited.

Good

Is the service caring?

Our findings

People were treated with kindness, respect and compassion. People told us, "They are all very kind. Very kind.", "The staff chat quite a lot, but they're not intrusive." Another said, "If you are a bit down, they come for a chat and try to liven you up." Staff took time to speak to people individually and reminisced with them. One person was talking about cockle picking at a local beach with a member of staff. They both knew the location well and this was clearly a happy memory for the person.

A health and social care professional told us about a person who had a pet before they moved to Beechwood House. They were missing their pet and how to support them around this was discussed with staff. Staff ordered a stuffed animal for the person. The health and social care professional told us, "This was a positive outcome as [the person] became more settled and [their] body language showed that [they] were now content in [themselves]."

Staff were person-centred. People's views on their identity and appearance were valued and respected. One person had specified a gender identity and this was respected by staff. Due to a health condition, their view of their gender had changed. Staff provide emotional and psychological support to allow them to live the life that they chose. People's preferred names were used. People's religions and culture were considered and supported by the service. Regular church services were held at the service and staff told us they would support anyone's cultural or religious preferences.

Staff were compassionate and empathetic. One person became distressed, concerned about where they were. Staff took time to sit with the person and clearly explain to them where they were, and address specific concerns they had. The member of staff returned to person three times to ensure they were happy with the explanation and that their distress soothed. The person became more relaxed and was later smiling and laughing with others.

People told us they could chose when to have support from staff. One person told us, "You can say, 'No, come back later.'" Another person said, "I've never felt you don't get the support. I'm very happy here."

People told us that their privacy was respected. One person said, "They shut the door. You can be private if you want to be private. They knock the door and wait until I say, 'Come in.' They don't just walk in." People's care plans included reminders about people's privacy and the importance of keeping the information confidential, to those reading them.

People's dignity was promoted. For example, one person had been sleeping in the lounge. Staff woke them and explained they may be more comfortable and have more privacy in bed. This support was offered sensitively.

People told us they could meet with their visitors where they wished to. One person said, "It's pretty free and easy. We meet in the room or here in the lounge or wherever." A relative told us, "They are extremely caring towards [person] and us. They make life easier for us. They look after [them] and us as well. And they've said

I can stay here if [person] is not very good and I was worried." Another relative told us the service provided "companionship, stimulation, kindness and professional care."

People and their relatives were involved in making decisions about the support from the service. Regular meetings were held and people's views were listened and responded to. One person told us, "If I ask for something, I've always got it." For example, the cleaning at weekends had been raised in a meeting and the registered manager had responded by ensuring that domestic staff were available at the weekend. Records of discussions with people's family were kept in the person's file to ensue all staff knew about relevant discussions.

Independence was encouraged and promoted. A relative told us, "They encourage [person] to do the things [they] can, but they don't just let [them] struggle." Staff respected the way people chose to live their lives, offering support and ideas as appropriate.

Good

Is the service responsive?

Our findings

Activities were adapted to people's interests and abilities. The service had begun a Namaste programme of activities, aimed at those people who spent most of their time in bed or in their rooms. This included sensory stimulation, by way of massage, music and other activities. A relative told us, "He has a better quality of life. I couldn't do a fraction of the things they do for him. He's much brighter. He has the best quality of life he can have." Staff told us that although they had begun the programme for those spending time in their rooms, they had also identified other people who benefited from the activities and so were changing one of the lounges to become more of a sensory area.

There were a variety of activities available, and people were encouraged and supported to join in. Activities planned for the week were advertised on a board in the hallway. We saw people take part in quizzes, discussions about the newspaper, darts, animal bingo, dancing and singing. People were encouraged to take part at the level that suited them, for some this meant singing the songs and for others they shook a musical instrument or were content to watch others.

Staff supported people to challenge themselves and celebrated their successes with them. For example, one person was supported to throw a dart to a dart board. This was clearly a positive development for the person for the person who was living with advanced dementia, and staff and their family joined them to celebrate their success.

People were involved in the local community. A relative told us, "They go to coffee morning. [Relative] goes into the village when they use the wheelchair." We saw people leaving the service to attend the local coffee morning. People told us, "They have church three times a week, you can go and have a chat."

The service had designed information leaflets to be available for people and their families. The registered manager had designed some leaflets to explain some areas, such as what a Deprivation of Liberty Safeguard assessment is, and what to expect during someone's final days. The registered manager explained that these helped relatives to more easily understand these processes, know what they could expect and empower them to be involved. The service also displayed a resident's charter of rights, explaining what people could expect from Beechwood House.

People's final wishes were considered and staff advocated these. Care plans considered whom people wished to be involved with decisions, if they were not able to, where they wished to be supported and which treatments they would had preferences about. People's religion was considered and their preferences after death. For example, staff told us about one person who came to Beechwood House for their final days. Staff spoke to the person about their wishes at the end of their life, including who they wished to be present and the type of medicines they would prefer. The service had respected and advocated these wishes, meaning the person had the death they wanted, surrounded by the people and the religious support they wanted, in the place they wanted to be. We read one detailed letter from a person whose relative had passed away at the service. This letter praised the excellent care their relative had received and described that the staff had gone above and beyond expectation by providing emotional support to the relative and providing them

specific meals. The relative praised the care and support they and their loved one had received and the difference it had made to their experience, meaning they could concentrate on their loved one in their final days.

People had also been supported around the end of their loved one's lives. One relative told us that their relative had been supported to attend a family member's funeral by staff. The member of staff had stayed throughout the funeral and remained afterwards to assist the person to return to Beechwood House.

Staff had been supported to increase their skills around people's end of life care. The service had recognised that there was a need for opportunity for additional training and had arranged a bereavement day. Staff went to a chapel of rest, visited the mortuary, observed a funeral service, and visited the local crematorium. This meant that they could confidently and correctly answer people, and their relatives' questions about these areas.

The service had published a monthly newsletter which included birthday celebrations, activities undertaken and those planned for the following month.

Care plans involved people and their relatives, as appropriate. The person's abilities and preferences were considered and then those areas in which they may need staff support. Action plans then guided staff how to provide that support.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. People's communication needs and preferences were considered during assessment and care planning. We saw that tools to assist people's communication were in use. For example, one person with hearing loss used a communication board. The service also considered the communication needs and preferences of visitors to the home and applied the principles of the standard to this communication too. For example, one person's relative had communication need. The service understood the best form to communicate with this person and told us they gave them notice of any meeting. This allowed the person them time to ensure they could get the right support for them to fully participate in the meeting.

A clear complaints policy was available. The service had not received any complaints recently, but had received a number of compliments. Relatives told us that if they had raised any concerns, these were responded to quickly. People told us they knew who to speak to it they had any concerns.

Good

Is the service well-led?

Our findings

There was a registered manager in post. Staff told us they were very well supported by the registered manager and management team. One member of staff told us, "The manager is the best. They are supportive and not biased, treating all the same." Staff told us the registered manager had an open-door policy. This meant they could come and discuss their ideas and thoughts, and if they were experiencing any difficulties, and receive support.

A health and social care professional told us the service was well-led. They said, "When the manager is away the delivery of care is the same as is the recording of observations." A person's relative told us, the registered manager was, "Very hands on."

The registered manager met regularly with the staff team. Staff were involved in deciding what was discussed at these meetings. Staff told us meetings were well attended, and help them identify areas that were working well and any that needed improvement.

People, their relatives and others were involved in the decisions about the service. Plans for events and changes were discussed at regular meetings which people and their relatives were encouraged to attend. People told us they could speak to the registered manager and that action would be taken. One person said, "I talk to her like she's another nurse."

The service works in partnership with other agencies to improve outcomes for people. A health and social care professional told us, "The staff all work well as part of multi-disciplinary teams." Other professionals told us that the staff team asked for, listened to and acted on advice. One health and social care professional told us, "As a service they work well with other professional disciplines." Another health and social care professional acknowledged the improvements the management team had made. They told us, "The home I feel provides very good care and are very attentive to the client's needs, both [registered manager] and [deputy manager] have worked hard to improve care and I feel very happy to have patients registered in this home."

There was a clear governance framework, which was completed regularly. The auditing system followed the CQC's key lines of enquiry. For example, one audit looked at how well people were protected by the prevention and control of infection, another looked at whether lessons were learned and improvements made when things go wrong. Any action required was clearly recognised, timescales were identified and progress monitored until compete. An ongoing action plan, made up of areas arising from any audit undertaken in the service was displayed and updated in the registered manager's office.