Care Quality Commission

Bethesda Healthcare Ltd

Westhampnett Nursing Home

Inspection report

Westhampnett House
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Chichester
West Sussex
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Tel: 01243 782986
Website:

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Ratings

Overall rating for this service	**Good**
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?	**Good**

Overall summary

The inspection took place on 18 August 2015 and was unannounced.

The home provides care and accommodation, including nursing care, for up to 32 people and there were 24 people living at the home when we inspected. These people were all aged over 65 years who had needs associated with old age and frailty including nursing care needs.

A combination of single or double bedrooms were available for people. Shared bedrooms were only provided when two people, such as a married couple, or partners, wished to share. There was a communal lounge and dining area as well as a conservatory which people could use. The home had attractive gardens with seats and tables.

The service had a registered manager but this person was no longer working in the role. They had applied to cancel their registration with the Commission, but this had not been completed correctly. A registered manager is a person who has registered with the Care Quality

Summary of findings

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. There was a new manager who had been in post since July 2015 and had applied to register with the Care Quality Commission.

Adequate checks were not carried out on newly appointed staff to ensure only those staff suitable to work in care setting were employed. This included lack of reference checks from previous employers and a lack of checks that nurses were registered with the Nursing and Midwifery Council (NMC) as 'fit' to practice. The manager took immediate action following the inspection by carrying out checks that all nursing staff were registered with the NMC.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or they reported any abuse. People said they felt safe at the home.

Care records showed any risks to people were assessed and there was guidance of how those risks should be managed to prevent any risk of harm.

There were sufficient numbers of staff to meet people's needs although staff felt there were times when this was not the case.

People received their medicines safely but there was a lack of clarity regarding one person's medicine which was prescribed to be taken on an 'as required' basis.

People told us they were supported by staff who knew their needs and preferences. Staff had access to a range of relevant training courses and said they were supported in their work.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff were not fully aware of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) and additional training had been arranged in these topics. Despite this, staff had followed the principles of the MCA Code of Practice in obtaining lawful consent. There were policies and procedures regarding the assessment of people who may not have capacity to consent to their care and the manager knew when these procedures needed to be used.

There was a choice of food and people were generally complimentary about the meals. Referrals were made to the dietician and relevant health care professionals so people were supported with any special dietary requirements.

People's health care needs were assessed, monitored and recorded. Referrals for assessment and treatment were made when needed and people received regular checks such as dental and eyesight checks.

Staff were observed to treat people with kindness and dignity. People were able to exercise choice in how they spent their time. Staff took time to consult with people before providing care and showed they cared about the people in the home.

People were consulted and agreed to their care. Each person's needs were assessed and this included obtaining a life history of people as well as ascertaining their preferences for their daily lives. Care plans showed how people's needs were to be met and showed how and when people were supported or treated by the care and nursing staff.

Activities which were appropriate to people's age and interests were provided. For example, people were supported to attend services at a nearby church. On the day of the inspection people were taking part in a presentation and discussion about the popular culture of the 1960s. People were observed in communal areas reading their daily newspaper and chatting with each other.

The complaints procedure was available and displayed in the entrance hall. There was a record to show complaints were looked into and a response of the findings made to the complainant.

The service promoted a person centred culture. Staff were committed to treating people as individuals, by providing a personalised service to each person and to giving the best care they could.

There has been a recent change of manager and the new manager was introducing additional audits checks so any

Summary of findings

trends could be identified and appropriate action taken. A number of other audit tools were used to check on the effectiveness, safety and quality of the service. This included seeking the views of people and staff.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Requires improvement

The service was not always safe.

Staff recruitment procedures were not safe as adequate checks were not made that newly appointed staff and nurses were suitable to work in a care setting.

People received their medicines as prescribed with the exception of an 'as required' medicine for one person. This meant there was a risk the person may not receive the medicine when they needed it.

Risks to people were assessed and guidance recorded so staff knew how to reduce risks to people.

Sufficient numbers of staff were provided to meet people's needs.

Is the service effective?

Good

The service was effective.

People were supported by staff who were well trained and had the skills to provide effective care.

People's capacity to consent to care and treatment was assessed but not all staff were aware of the principles and procedures as set out in the Mental Capacity Act 2005 Code of Practice. Additional training had been arranged to address this.

People were supported to have a balanced and nutritious diet. Special dietary needs were catered for. Health care needs were monitored. Staff liaised with health care services so people's health was assessed and treatment arranged where needed.

Is the service caring?

Good

The service was caring

People were treated with kindness and dignity by staff who took time to speak and listen to people.

People were consulted about their care.

The staff promoted the privacy of people who were able to exercise their independence.

Is the service responsive?

Good

The service was responsive.

People received personalised care which reflected their needs and preferences. Care needs were reviewed and changes made to the way care was provided when this was needed.

Summary of findings

Activities and entertainment were provided based on what people wanted.

There was a complaints procedure and complaints were looked into and responded to.

Is the service well-led?

Good

The service was well-led.

The provider sought the views of people and their relatives about the quality of the service to check where any improvements needed to be made.

Staff were aware of their responsibilities and were committed to treating people as individuals.

The home had a new manager who staff described as approachable. There were systems for auditing the quality and safety of the service provided to people and the new manager was introducing additional audits to enhance this.

Westhampnett 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. The inspection checked 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 18 August 2015 and was unannounced.

The inspection team consisted of an inspector and an Expert by Experience, who had experience of services for older people. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

During the inspection we spoke with seven people who lived at the home and with a relative. We also spoke with two care staff, two registered nurses, the chef, the manager and a member of the provider's administrative team.

Some people who used the service were unable to verbally share their experiences of life at the home because of their complex needs. We therefore spent time observing the care and support they received in shared areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care plans and associated records for five people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Records for four staff were reviewed, which included checks on newly appointed staff and staff supervision records.

We spoke with a community nurse who treated people at the home. This professional gave their permission for their comments to be included in this report.

This service was last inspected on 19 February 2014 and there were no concerns.

Requires improvement

Is the service safe?

Our findings

The provider's staff recruitment procedures were not safe.

We looked at the recruitment procedures for three staff; two had recently started work at the home. A Disclosure and Barring Service (DBS) check had been obtained for each of these staff. The DBS check identifies if potential staff are unsuitable to work in a care setting.

For one of these staff there was no record of any reference checks being obtained. The manager did not know why there were no references for this staff member. Another staff member had also been employed without references being obtained. We were told by the manager these were requested but had not been returned. Following the inspection we were sent a copy of a note made by one of the staff who recruited the staff member which said references were requested at the time of the staff member's recruitment. For a third staff member, the references consisted of a note entry on a sheet of paper of a telephone reference. A second reference had been obtained but this was not from one of the more recent previous employers. Following the inspection the provider wrote to us to confirm written references had been obtained for these staff.

Of the two registered nurses whose records we looked at there was no record of the provider checking the nurses were registered with the Nursing and Midwifery Council (NMC) as fit to practice. The nurses had supplied historical NMC checks from a previous employer. After the inspection the manager confirmed they carried out a check that each nurse employed at the home was registered with the NMC.

The provider had not carried out the required checks on newly appointed staff to ensure only those who were suitable to work with people at risk were employed. This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received safe care and that they felt safe at the home. Staff said they considered people received safe care at the home. Staff were aware of the procedures for reporting any suspected abuse or concerns and knew they could contact the local authority safeguarding team regarding any concerns. There were policies and procedures regarding the safeguarding of adults and staff received training in this.

Risks to people were assessed and recorded. There were corresponding care plans so staff had guidance on how to support people to reduce the risk of injury or harm. These included the risks of falls, the risk of pressure areas developing and the use of bed rails to keep people safe when they were in bed. The manager and a member of the nursing team told us how any incidents or accidents were reviewed to identify if any changes were needed to support people safely. Care plans were also reviewed each month. We saw a record of a review of care following a person experiencing a fall to reduce this risk in future. This meant there were procedures so the person was safely supported. Each person had an emergency evacuation plan so staff knew how support people to leave the building in the event of an emergency. A community nurse commented how staff used safe moving and handling techniques.

The provider did not use a dependency tool to assess the required staff levels but used a ratio of one staff to five people in the morning and one to seven in the afternoon. The home employed eight registered nurses and 15 care staff. There were four care staff on duty from 0800 to 1400 and three care staff from 1400 to 2000. There was at least one registered nurse on duty in the home at all times. We observed these staff levels were provided at the time of the inspection. Staff were observed to be responsive to people's needs and were available to support people.

Staff gave us mixed views on the staffing levels. One staff member thought they were generally sufficient but there were times when it would be preferable to have more such as during busy periods. Staff referred to the service having its own pool of bank staff which were used when staff were on leave to cover any vacancies. A staff member said how the use of bank staff provided care staff and registered nurses who knew people's needs. Another staff member said the staffing was not sufficient adding there were only three care staff on duty at the time of the inspection. This was discussed with the manager who confirmed this was incorrect as a staff member who absent due to sickness was replaced by another staff member, which we also observed.

Medicines were administered to people as prescribed. Blister packs of medicines and the medication administration records showed people received their medicines as prescribed. Appropriate blood checks and records were completed where people needed insulin or warfarin to ensure they were given at the right dose at the

Requires improvement

Is the service safe?

right time. For one person there was no care plan guidance of when rectal diazepam should be given. This medicine was included in the stock of medicines for the person but was not included on the current medicine administration record chart supplied by the pharmacist. However, one of the registered nurses said they would not administer it as it was not on the current medication record chart. This needed to be clarified so staff were clear on whether it was prescribed and relevant guidance incorporated into the care plan to advise staff when this medicine should be given.

We checked the procedures for the storage, handling and administration of controlled medicines. These were in accordance with the required guidelines.

Staff who handled medicines received training in the management of medicines. This included an assessment of their competency to do so.

Good

Is the service effective?

Our findings

People benefited from staff who had the skills and knowledge to meet their needs. People said they got the right support from the registered nurses and the care staff. People commented on how well the registered nurses and care staff managed their continence needs, diabetes and wound care. For example, one person commented, "I am very happy with the nurses' stringent care of my diabetes illness "

We observed staff consulted people before they provided care to them.

Staff told us they received an induction when they started work at the home and that this gave them sufficient guidance to provide care to people. We saw records to confirm newly appointed staff received an induction. Staff commented on how the induction process involved working alongside more experienced staff so they were able familiarise themselves with the care procedures and people's needs.

A range of training courses were provided for staff. Nine staff had completed the National Vocational Qualification (NVQ) in care or the Diploma in Health and Social Care. National Vocational Qualifications (NVQs) are work based awards that are achieved through assessment and training. To achieve an NVQ, candidates must prove that they have the competence to carry out their job to the required standard. The manager maintained a training spreadsheet with details of the training courses completed by staff. This allowed the manager to monitor which staff had completed training considered essential to their role and when this needed to be updated. The training included fire safety, safeguarding adults procedures, moving and handling, dementia care and infection control. Staff confirmed they attended this training. One of the registered nurses said staff were particularly skilled in supporting those who needed end of life care. Specific training for the nurse or care staff had not been provided in this but advice was sought from a hospice. A community nurse considered staff and registered nurses were skilled in providing care and that staff attended any training provided by the community nursing team.

Staff told us they received supervision which consisted of a one to one meeting with their line manager and that the way they cared for people was monitored. Staff said they felt supported in their work and had access to guidance and advice from the nurses and the manager.

Not all staff had received training in the Mental Capacity Act 2005 (MCA) and were not fully aware of this legislation and the associated guidance in the Code of Practice. This legislation sets out the procedures to be followed if people do not have the capacity to consent to their care and treatment. The manager was aware of the procedures to be followed where people did not have capacity to consent to their care and treatment. The manager told us a training programme had been devised by the provider, which will be used to train staff in this area in the near future. There was a notice in the staff room of the training programme in the MCA and in the Deprivation of Liberty Safeguards (DoLS).

People were consulted and had agreed to the support they received. Care plans included a signature where people had agreed to their care. People's care records showed their capacity to consent to care and treatment had been assessed. The provider had made applications to the local authority for a Deprivation of Liberty Safeguards (DoLS) authorisation for those people who were not able to consent to their care and treatment and had their liberty restricted for their own safety. Four people were subject to a DoLS authorisation and the manager stated further applications will be made for the remaining people where this has been assessed as appropriate. The manager also said a 'best interests' meeting had recently taken place to discuss and agree the appropriate care for someone who did not have capacity to consent to their care. In view of the lack of training for all staff regarding the Mental Capacity Act 2005 and Code of Practice, as well as the ongoing process of making DoLs applications for people, this is an area the provider has identified as being in need of further attention and was taking action to address this.

People generally spoke favourably about the food. They said cooked breakfasts were provided which they enjoyed. People said fresh fruit and vegetables were available. Two people made negative remarks about the food being "overcooked" and a "little institutionalised," but said they liked the food despite this. People confirmed there was a choice of food and we saw people were asked what they would like to eat. We spoke to the chef who had a good

Good

Is the service effective?

knowledge of people's dietary needs and preferences and said these were catered for. The chef commented that the food stocks were adequate but added there were occasions when substitute alternative foods were sometimes used. We saw meals were freshly made.

We observed lunchtime in the dining room. This was initially lacking in organisation as people were seated at dining tables which had not been cleared from previous activities. One table had crumbs on it which staff cleared away after people were helped to sit down. One table was set with cutlery after people had sat down. Tables were set with table cloths and napkins to enhance the experience of eating. People enjoyed the lunch time and were seen chatting to one another. Staff supported people where this was needed.

People's dietary needs were assessed using a malnutrition universal screening tool (MUST). This identified those at risk of malnutrition or dehydration. People were referred to either the dietician or speech and language therapist if needed. For example, we saw one person was assessed by the speech and language therapist and advice was provided as the person had problems with swallowing food. The advice was provided in a letter by the speech and language therapist dated 7 August 2015. The person's care plan had not been updated since the letter was received. The chef's record of the need to provide certain pureed foods for this person had also not been updated. The chef and staff, however, were fully aware of the advice from the speech and language therapist and said this was always followed. A nurse and the manager told us the advised pureed food was provided and agreed the care plan needed to be updated to include the current advice from the speech and language therapist. The chef was also able to tell us how other specialist diets were provided such as diabetic diets and where people were allergic to certain foods. A community nurse commented that the food was of a good quality and a choice was provided. Advice from the community nursing team regarding meals being fortified to give greater nutrition was followed by the staff.

People were supported to have their health care needs met. People spoke highly of the support they received from the registered nurses to manage their health care needs such as any wound care or diabetes. A member of the community nursing team told us people's health care needs such as wound care were met by staff and that any advice provided by the community nurses was followed. The community nurses said referrals for assessment and treatment were made appropriately by the staff. Care records showed how health care needs such as diabetes were managed and treated, which included tissue viability care plans to manage pressure areas. Monitoring records showed the management of pressure areas was effective. Records showed the pressure area was successfully treated.

People were referred to health care professionals when this was needed. This included district nursing service and the GP. Records showed people were supported to have eye sight checks, chiropody and dental treatment to maintain their overall health.

Good

Is the service caring?

Our findings

People told us they were treated well by the staff. For example, one person said, “The staff do all that they can for you,” and another said, “The staff are wonderful and marvellous.” People said their privacy was acknowledged and they were able to make choices in how they spent their time. One person said they were able to get up later as this was something they did when they worked. The staff and manager were aware of this and acknowledged this in the way the person was supported. Another person told us how they preferred to spend time in their room and that when they had visitors staff always made them feel welcome. A member of the community nursing team told us staff were flexible so people could choose how they spent their time; staff were also said by the community nurse to spend time with people.

We observed staff interacting with people throughout the day and we carried out an observation of staff and people at lunch time. Staff spoke to people in a kind manner and were respectful to people. Staff gave people clear explanations about how they were trying to support them and offered people choices. Staff were observed to pay attention to the detail of what people wanted by asking them how they wanted their food and drinks.

There was a rapport between people and staff, which demonstrated staff were aware of people’s needs and interests as they engaged in conversations with people about topics of interest. Staff also showed patience and calmness in supporting those with specific needs at lunch time and when people appeared distressed. Care plans included details about people’s psychological needs so staff could support people with these.

Staff told us people were treated as individuals using a person centred approach. Staff were committed to their work and said they liked to spend time talking with people as well as giving the best care they could. Staff commented on the importance of treating people with dignity and for helping people to be independent. Staff recognised the rights of people to be treated equally.

Care records showed how people were involved and had contributed to decisions about their care. People’s preferred routines were included in how care and support was provided. Care plans were written in a person centred way with the person’s needs and preferences as the focus of how care was to be provided.

Each person had their own bedroom unless they chose to share with a spouse or partner. This gave people privacy. People were observed pursuing their own interests and being independent. People said how they went out to the church and received visitors. There was a kitchenette where visitors could make their own drinks and refreshments. Relatives said they were able to visit when they wished.

A community nurse commented that staff were skilled in recognising when people needed end of life care and provided appropriate care and treatment so people could be supported in the home if this was their choice. The community nurse said this involved the provision of specific equipment so people’s end of life care needs were met.

Good

Is the service responsive?

Our findings

People described how their care needs were met and how responsive the staff were. This included dealing with changing health care needs. One person reported there had been an improvement in staff responding to the call point in their room. We saw a notice in the staff room from the manager instructing staff to respond promptly when people asked for assistance by using call points in their room as this was identified at a recent audit check.

People's needs were assessed when they were admitted to the home. People told us they were asked about their needs and preferences at this time. There was an admission checklist pro forma completed for each person to help ensure all care needs were assessed. A life history for each person was recorded so staff were aware of people's family and work history.

Care records were individualised to each person. These were recorded in a way which reflected people's preferences for how they were supported. For example, there was a Lifestyle Choices care plan which included details about people's preferred daily routines. The care plans also took account of what people could do themselves so they were able to maintain their independence, such as what aspects of personal hygiene they could manage themselves and which areas staff needed to provide support with.

Daily care records showed people received the identified care by staff, such as treatment for wounds and pressure areas. Care plans were regularly reviewed and updated to ensure care was meeting people's needs and preferences.

Activities were available for people and they were able to choose whether they wished to join in or not. We observed a presentation by an outside activities provider to a group of people in the lounge. This was about 1960s popular culture and included visual images and music. The presentation was appropriate to people's age and people were motivated to join in with a discussion or enjoyed the music. People said they were generally satisfied with the activities. One person said the activities were too undemanding and simple and said they preferred to spend time in their room completing a crossword with a staff member. We observed staff spending time chatting to people and people told us they enjoyed this but wished staff had more time to devote to this. We observed people reading in the lounge areas and people said they went out with staff, or on their own or with friends and relatives. People were supported to attend the local church and there was a notice about religious services in the home.

At the time of the inspection there were no residents' or relatives' meetings where issues or concerns could be discussed. The manager planned to introduce these in the near future.

People said they knew what to do if they had any concerns or complaints adding they would speak to one of the nurses. The complaints procedure was displayed in the hall. There was a complaints log book which detailed how each complaint was investigated, the outcome of the investigation and the response to the complainant.

Good

Is the service well-led?

Our findings

People felt able to raise concerns with the staff and manager. People confirmed they were asked to give their views about the home and people and their relatives had completed survey forms in September 2014. These showed people and their relatives were satisfied with the standard of the service provided. A survey was also provided to those people who were leaving the service so their experiences could be considered in any future planning.

The service had links with the local community such as the local church and people were supported to attend community activities.

The manager and staff demonstrated a commitment to person centred care and a set of values which included people being treated with dignity. The service had a new manager who had applied for registration with the Commission and had been in post for less than two months at the time of the inspection. The manager had already introduced changes and improvements to the delivery of the service, which staff also confirmed. This included memos to staff about the need to respond promptly to people when they asked for help when using their call points and the introduction of additional training.

The home's management and staff had established positive working relationships with the NHS and other health care providers so people received the right care and treatment. A member of the community nursing team said the manager was open and transparent and sought advice which was then followed regarding people's care needs. The community nurse said staff had a good working relationship with the local GP practices and the community health services. One of the registered nurses at the home said the staff were particularly skilled in end of life care and sought the advice of a local hospice about individual care for people so care was in line with current best practice guidance.

The manager stated they worked alongside staff to achieve a good standard of care for people. Staff said they were able to express their views about the service at the staff meetings and had regular opportunities to discuss people's care needs. Staff showed they had values of compassion, respect and equality in how they treated people.

Audits were carried out on a regular basis to check the standard of care and whether people received safe care. The results of these audits were compiled into a report completed by the provider and were available for us to see. These included audits of care plans, documentation and medicines. The manager stated their intention to extend the system of audits. Care records showed any incidents were looked into and amendments made to how people were supported to prevent any reoccurrence. The manager recognised there was no system to record incidents such as falls so that any trends could be identified. This was to be introduced by the manager and would help identify if any action could be taken to prevent reoccurrences of incidents.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Recruitment procedures did not ensure only 'fit and proper' staff of good character and who had appropriate qualifications and skills were employed. This included checks as required by Schedule 3 of the Regulations.** Regulation 19 (1) (a) (b) (2) (3) (a) (b) (4) (a) (b).