Contemplation Homes Limited

Beechcroft Manor Nursing Home

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

Overall summary

This inspection took place on 13 August 2015 and was unannounced.

Beechcroft Manor Nursing Home is registered to provide accommodation, personal care and nursing services for up to 18 older people and people who are living with a physical disability. At the time of our inspection there were 12 people living at the home. People were accommodated in single rooms, some with en suite facilities. There was a shared lounge, dining room and an enclosed garden.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 were appropriate processes and risk assessments in place to protect people from risks to their safety and wellbeing, including the risks of avoidable harm and abuse. Staff were aware of their responsibilities to recognise and report signs of abuse. Arrangements were in place to keep people safe and comfortable in the event of an emergency evacuation.

The registered manager made sure there were enough staff with the right skills and knowledge to support people safely. Staff stored and administered medicines, including skin creams and ointments, safely. Medicines records, including for medicines prescribed "as required" were accurate and complete.

Staff were supported to obtain and keep up to date the skills and knowledge they required to support people. They were aware of the need to obtain people's consent and were guided by the Mental Capacity Act 2005 where people lacked capacity to make certain decisions. Where people lacked capacity and were at risk of being deprived of their liberty in order to keep them safe, the registered manager had applied for authorisation under the Deprivation of Liberty Safeguards.

The service provided varied, nutritious meals which were prepared and served according to people's individual needs. People had access to their GP and other healthcare providers when needed.

Staff had established caring relationships with people. They knew about their life history and interests, and spent time chatting with them when they were not actively supporting people. Staff supported people to take part in decisions about their care and support, and people were listened to. Staff respected people's individuality, privacy and independence.

People received care and treatment that met their needs and took into account their wishes and preferences. Staff delivered care and treatment in line with plans and assessments that included the management and treatment of longer term medical conditions. The service had a procedure in place to manage complaints, but people had not felt the need to use it.

Staff supported people in a variety of individual and group activities, including trips outside the home. Staff encouraged and supported people to take part in activities so they did not feel excluded.

People, their families and staff were all complimentary about the atmosphere and culture in the home. People expressed affection for the home and its staff. Staff expressed pride in the service provided, and described it as homely and well run.

The registered manager had an effective and organised management system, and had introduced imaginative methods to maintain the quality of the service and to communicate their priorities and values.

There was a thorough and wide ranging system of checks and audits to monitor and assess the quality of service. Actions arising from these checks were followed up.

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 safe

People were protected against risks to their health and wellbeing, including the risks of abuse and avoidable harm.

There were sufficient numbers of suitable staff to support people safely and meet their needs.

People were protected against risks associated with the management of medicines. They received their medicines as prescribed.

Good

Is the service effective?
The service was effective.

People were supported by staff who had the knowledge and skills needed to carry out their responsibilities.

Staff obtained people's consent to their care and treatment. They followed legal guidelines to make decisions in people's best interests where people lacked capacity to make certain decisions themselves.

People were supported to have a balanced diet. Their health and welfare was maintained by access to the healthcare services they needed.

Good

Is the service caring?
The service was caring.

People had positive relationships with the staff who supported them.

People were able to make their views and preferences known. They were encouraged to take part in reviews of their care.

People's independence, privacy and dignity were respected and promoted.

Good

Is the service responsive?
The service was responsive.

Staff delivered care, support and treatment that met people's needs, took into account their preferences, and was in line with people's assessments and care plans.

People were able to take part in individual and group activities that took into account their interests and choices.

A procedure was in place to manage complaints, but people told us they had no concerns to raise.

Good

Is the service well-led?
The service was well led.

There was a friendly, homely and professional atmosphere in the home, which was appreciated by people, their families and staff.

Good

Summary of findings

Management of the service was effective, organised and imaginative.

Systems were in place to monitor, assess and improve the quality of a wide range of service components. These included regular audits and unannounced spot checks.

Beechcroft Manor 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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on 13 August 2015 and was unannounced. The inspection team consisted of an 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. On this inspection the expert by experience had experience of both visiting friends or relations and of working in nursing homes.

Before the inspection we reviewed information we had about the service, including previous inspection reports and notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law. The registered provider gave us additional information on the day of the inspection.

We spoke with or observed care and support given to all 12 people living at the home. We spoke with three visitors. We observed care and support people received in the shared areas of the home, including part of a medicines round and the lunch period.

We spoke with the registered manager, the registered provider and other members of staff, including the training manager, a registered nurse, two care workers, an activities coordinator, two cleaners and a cook.

We looked at the care plans and associated records of three people. We reviewed other records, including the provider's policies and procedures, emergency plans, internal and external checks and audits, company testimonials, training, appraisal and supervision records, staff rotas, and recruitment records for two staff members of staff who had joined the service recently.

Good

Is the service safe?

Our findings

People told us they were kept safe. One person said, "Safe? Oh yes, I am very safe. Everyone is kind, always. They are a lovely bunch." Another person said, "It is nice. Safe – oh yes. And polite. All is very pleasant." People did not have to wait more than a few minutes if they needed help. They received their medicines at the right time, and they could ask for more pain relief if they needed it.

The provider took steps to protect people from risks including avoidable harm and abuse. Staff were made aware of the types of abuse, the signs and indications of abuse, and how to report them if they had any concerns. All the staff members we spoke with were confident people were safe from the risk of abuse. If they had any concerns they were certain they would be encouraged to report them and that they would be handled promptly and effectively.

The registered manager was aware of processes to follow with the local authority if there was a suspicion or allegation of abuse. Training was in place to maintain staff knowledge about safeguarding. There was a mandatory module on safeguarding in the induction for new staff, and it was included in the training and development plan for all staff. The provider had suitable procedures and policies in place for safeguarding and whistle blowing.

Risks to people's safety and wellbeing were managed by appropriate risk assessments. These included risks associated with eating and drinking, difficulties breathing, infections of the urinary tract, and the use of wheelchairs. Care plans took into account the relevant risk assessments and contained instructions for staff on how to manage the risk.

If the registered manager received information or alerts about possible risks associated with products or equipment in use in the home, they put appropriate individual risk assessments in place. For example, following an alert about the possibility of people swallowing the powder used to thicken their drinks, they identified who might be exposed to this risk. The people identified had risk assessments in place with instructions for staff to reduce the risk.

Procedures were in place to keep people safe in an emergency. The service had an emergency plan and people had individual evacuation plans. These contained information about the support the person would need to during an evacuation and their emergency contact details. An up to date copy of these plans was kept in a convenient place to pick up in an emergency. In the event of an evacuation, there was an agreement with other nearby homes owned by the provider to provide temporary accommodation.

The annual fire risk assessment was up to date. There were no actions arising from the most recent report. Other risk assessments included the cleaning of clinical waste bins, the use of the laundry, and moving furniture and other heavy items.

There were sufficient numbers of suitable staff to support people and keep them safe. Staff told us their workload was manageable. The registered manager told us staffing levels were based on people's needs and would be increased if people's needs changed or when more people came to live at the home. We saw staff were able to support people in a calm and professional manner. They used opportunities to spend social time with people when they were not supporting them.

The provider carried out the necessary checks before staff started work to make sure they were suitable to work in a care setting. Staff files contained evidence checks were made on proof of identity, a criminal record check, employment history, good conduct in previous employment and professional registration where appropriate. The registered manager used interviews based on a standard set of questions with a scoring system according to the answers given to identify suitable candidates. New starters had a three month induction based on the Care Certificate which provides a set of nationally agreed standards for people working in social care.

Medicines were stored and handled safely. Arrangements were in place to receive medicines, record them, store them securely according to the manufacturers' guidance, and dispose of them safely.

People's medicines records contained individual instructions for staff when administering medicines, information about their medical conditions and allergies, and preferences with respect to taking their medicines. Where people had prescribed skin creams, the instructions included a body map to show where the cream should be applied. The nurse administered people's medicines in a friendly manner and according to the person's preferences.

Good

Is the service safe?

They made sure the person had a drink and had swallowed their tablets before thanking them and moving on to the next person. They offered pain relief if the person had a prescription for "as required" medicines and had guidance including a checklist to estimate the person's pain level if they could not communicate verbally if they were in pain.

Records of medicines administered, including skin creams and medicines prescribed "as required" were complete and accurate. The nurse recorded the dose and time of administration in the case of "as required" medicines, which showed when the person could next safely have the medicine. Staff recorded the date they opened bottled medicines, and information was available about how long the different types of medicine could be kept after opening.

Good

Is the service effective?

Our findings

People were satisfied they were supported by staff with the appropriate skills and knowledge. Amongst testimonials for the home, one person's relation had written, "This home and staff excel in every aspect of care for the elderly." Another person had commented, "I like living here because I get looked after." Staff supported people to eat and drink where they needed assistance and this was done according to their preferences. Lunchtime was a lively, enjoyable time for people. People had access to other healthcare services when they needed them.

Staff had access to the training they needed to obtain and maintain the skills necessary to provide care and support to the standard required. They said they received appropriate and timely training and were supported by regular supervision meetings and by informal access to more senior staff. The induction for new staff members was based on nationally recognised standards. There was a schedule for mandatory refresher training. Staff were able to obtain relevant qualifications and received specialist training, such as in supporting people living with dementia and in using syringe drivers. (Syringe drivers are small pumps which deliver a steady dose of medicine over a period of time.) Staff were able to complete any training needed to maintain their professional registration.

Staff had annual appraisals with the registered manager and supervision sessions with their appointed supervisor. Some supervision sessions were themed according to a certain topic to build on learning from training sessions. They led to an assessment of the staff member's competency to practice. Records were in place to show which courses had been completed.

Staff were aware that people should consent to their care and treatment. Where people had consented this was recorded in their care plans. Staff also recorded people's consent in their daily logs of care delivered, for instance "[Name] consented to be fully assisted."

The registered manager and staff were aware of what to do if people lacked capacity to make decisions. Information about the Mental Capacity Act 2005 and the associated Code of Practice was available to staff. This provides a legal framework for acting and making decisions on behalf of people who lack capacity to make particular decisions for themselves. Records showed staff assumed people had capacity. Where there was reason to believe they did not, staff used a toolkit provided by the local authority which guided them to assess people's capacity and make decisions about their best interests according to the legal guidelines.

One person's care file contained decision specific capacity assessments for each area of care and support included in their care plan. These assessments were in line with the legal guidelines. Another person's care files contained information about a family member who had Lasting Power of Attorney for both property and financial affairs and for health and welfare. Records showed the family member was consulted appropriately.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. These safeguards protect the rights of people by making sure any restrictions to their freedom and liberty have been authorised by the local authority as being required to protect the person from harm. The registered manager was informed about a recent Supreme Court judgement which affected the scope of DoLS. They had applied to the local authority on behalf of a number of people living at the home who lacked capacity and were judged to be at risk of being deprived of their liberty.

People were encouraged to eat a healthy diet, and staff gave them appropriate assistance and support to eat. People used plate guards and beakers which helped them maintain their independence. Where people needed thickener in their drinks to help them swallow safely, this was done according to their needs and preferences. Staff offered to help, for instance by cutting up a person's food, but if the person declined their assistance, they respected this, and people were given the time they needed to enjoy their food.

People could choose from a standard menu which included two hot meals with a choice of main course. If there was nothing they liked on the menu there were other options available. The cook catered for people living with diabetes and people who needed their food to be pureed for them to swallow it. There were no other dietary requirements for reasons of medical need or people's preferences. The pureed meals were presented in an appetising way, and family members of a person who had pureed meals told us they enjoyed their food and it was always served with care. The service had a "very good" food hygiene rating.

Good

Is the service effective?

People's health and wellbeing were supported by access to healthcare services when needed. Records were kept of appointments with and referrals to other providers such as people's GP, chiropodists and opticians. Speech and language therapy and psychiatric consultations were used to inform people's care and support. There were frequent reviews of people's care with their social workers and the community mental health team. Staff supported people to attend outpatient appointments at the local hospital.

Good

Is the service caring?

Our findings

All the people we spoke with felt they were treated with kindness, dignity and respect. They told us they found the registered manager and staff to be very approachable. One said, "All the girls are lovely – no-one's unkind. They stay around and chat if you want to." Another person said, "All the carers are really and truly very good, sweet. I do cross-stitch with one of the girls." Family members said "Mum always seems happy here. You can't do better," and "It gives us peace of mind. Here, it's absolutely fantastic – the girls are lovely. They let us know if anything happens – like when they got the doctor in to her for a chest infection once – she was fine – everything is reviewed with [nurse]. They let [people] do things as they are able - take them out for fish and chips, and things like that."

Staff had caring relationships with people. They were cheerful and kind, and spoke about people with affection. They were aware of people's life stories and interests. They chatted with people in a friendly way while they supported them. One member of staff who was reading to people, paused to make sure they were involved and still enjoying it. They had found out from another person's partner their favourite singer and a book which had meaning to them. Staff read to them from the book and made sure they could listen to the music they enjoyed. The person's partner said, "They are very kind, very good here. [Name] has had dementia for ten years. She is looked after, kept comfortable and clean. She eats well and seems a bit more alert today."

People had a named nurse and a named care worker they or their family could approach about their care and support. The registered manager had started to nominate staff volunteers as "champions" in different areas of care. The intention was these champions would be the home's experts in their chosen area. They would wear a badge to encourage people and their families to approach them and be involved in their service.

People had the opportunity to take part in decisions about their care and treatment. They all had a copy of the service's handbook which gave them information about what the service could offer. They were involved in discussions with the service's nurses about options if they needed treatment for a medical condition. These discussions continued with the person's GP or specialist nurses if necessary.

Discussions about care and treatment also took place when people's care plans were reviewed every month and at meetings arranged for people and their families. The most recent of these took place a week before our visit. The record of the meeting showed people were invited to express their opinions and preferences, and the meeting was used as an opportunity to make sure people's relations were aware of their family member's care plan. One person was supported by a volunteer advocate to make sure their interests were taken into account in discussions about their care and support.

Staff respected people's privacy and dignity. They knocked before going into people's rooms and used signs on the door to show when they were supporting people with personal care. They used people's preferred names and were aware how they preferred to be supported. Staff gave us examples of how they preserved people's dignity and encouraged them to be independent. The registered manager's regular checks included a dignity audit during which the way staff interacted with people was observed.

Records containing information about people were protected and stored appropriately to maintain confidentiality. If information about how people preferred to be supported was kept in their room, this was inside their wardrobe so that it was not visible to a casual visitor.

None of the people living in the home had expressed preferences based on their religious or social background, but records showed this was taken into account in their care assessment. The topics of equality and diversity were covered in staff induction and ongoing training.

Good

Is the service responsive?

Our findings

People received assistance and support that met their needs and took into account their preferences and wishes. Everyone told us they could choose what time they got up in the morning and went to bed at night. Most said they slept well and were very comfortable. Those who wished to could eat in their rooms, although this varied according to their wishes on the day.

One person told us, "I usually eat in my room by choice, but it depends what's going on. If I eat up here, the girls will come and chat; and if there is bingo on, I'll come to the lounge." Another person told us, "I'll eat my lunch up here today, as [name of care worker] has just put my hair rollers in. I'm so lucky – I can have a bath every day, and I do my hair once a week."

People's care and support were based on assessments and plans that took into account their preferences, needs and medical conditions. Care plans took into account people's individual personality. They contained information in a one page profile about the person, a person centred profile, a wellbeing profile, and relationship maps which showed other people who were important to them.

The plans contained information about how people preferred to be supported and things they could do themselves. For instance, one care plan stated, "I can wash my own face," that the person liked to choose their own clothes and when they preferred to go to bed.

Where people were diagnosed with specific medical conditions, for instance cellulitis, high blood pressure, arthritis, and Alzheimer's disease, there were care and treatment plans in place. Where people were prescribed certain medicines their care plans contained guidance for staff about possible side effects. Records showed where treatment plans were successful, for instance one person's leg ulcers had healed completely. Staff were aware of the care and treatment people needed, and records showed they delivered care and treatment in line with people's plans. In the case of a person living with epilepsy, there was a diary which recorded their seizures. If they received their prescribed medicine, this was recorded along with a description of how effective it had been. Another person received regular hand massage to relieve muscle contractions. Where people needed assistance to turn in bed, records were kept. Where people's fluid intake was being monitored, the relevant charts were completed and their actual intake compared with the target amount. In one case staff had drawn a smiley face on the chart to share the achievement of the person reaching that day's target intake.

People could take part in various hobbies and activities according to their interests and wishes. Everybody agreed there was enough to do and occupy their time. One person said, "Well, I'm never bored, so I must be occupied enough." People told us they particularly appreciated opportunities to go on outings or trips to the shops, and they would be happy with more chances to do this. Another person said, "There is plenty to do. We go out in a taxi with a carer, when it's nice. We get games – we all enjoy those. It's nice to see pets come in sometimes too."

Hobby activities included gardening and cooking. People had recently been supported to make a painting of something important to them. Where a person had not been able to hold a paint brush, staff helped them to make a pattern by blowing on paint through a drinking straw, which meant they would not feel excluded from the activity. Staff kept records of activities and how people responded to them. In one example, a person was noted as having responded positively when staff included them in filling a photo frame with pictures and information about their life and things that were important to them.

Shared activities included an open day, and a day of seaside activities brought into the home. Photographs of these were displayed around the home to remind people about them and act as a talking point. Visiting family members told us how they appreciated the staff's enthusiasm for activities like these which often involved them dressing up and coming in when they were off duty.

Everybody told us they found the registered manager and staff approachable, and they would not hesitate to speak to them if they had any concerns about the service they received. However, none of them could think of an example of a concern.

The service had a complaints procedure which was displayed near the entrance to the home and in the staff area. The procedure was included in the information pack people received when they first moved in. The registered

Good

Is the service responsive?

manager maintained a log of complaints which contained one recent complaint raised by a visiting healthcare professional. The records showed it had been investigated and responded to appropriately.

Good

Is the service well-led?

Our findings

Beechcroft Manor Nursing Home had recently been closed for major refurbishment and people had moved to another of the provider's homes while the works were in progress. The refurbishment had included repairs, conversion of bedrooms to single occupancy and provision of en suite facilities in all but four of the bedrooms. All of the people we spoke with were very pleased to be back in their "own" home, which they "loved". Most of them volunteered these opinions without prompting from us. People and their family members were all complimentary about the leadership and management of the home. Visitors told us they were made welcome at any time.

Staff were enthusiastic about the improvements made to the home, proud of the service and motivated to provide the best quality service they could. They told us they liked working there. One member of staff said it was "lovely, like being in your own home", and another said it was "like another family". None of the members of staff we spoke with could think of anything they would change about the home. They responded positively to the registered manager's style of leadership, felt they could go to the manager at any time if they had a concern about people's care, and felt they were kept up to date and informed. They said they had a good relationship with the manager, and described the manager as "very good" and communications as "good".

The registered manager was enthusiastic, and had a clear vision and ambition for the service. They were starting to introduce initiatives, such as the use of a butterfly symbol on people's doors to indicate to staff in a sensitive manner when people were being supported at the end of their life. Their plan to nominate volunteer staff members as "champions" in areas such as oral health, dignity, infection control, continence, dementia, and nutrition had been discussed at the most recent staff meeting. The manager had written guidance so that the champions knew what was expected of them, had made badges with symbols to clearly identify the champions and their areas of expertise, and had introduced the idea at a meeting for people and their families. Although it was too soon to see the impact of this initiative on people's care, it showed an ambition to innovate and an awareness of how to include people and staff in a structured plan of implementation.

The management system included staff meetings with nurses, care workers, domestic and catering staff. These were used for two way communication with staff members able to add items to the agenda. The minutes of the most recent meeting were available in the staff area. In addition the registered manager attended shift handovers and worked closely with other staff, occasionally taking the duty nurse role on a shift. They delegated tasks to senior nurses and care workers and used posters and signs in the staff area to reinforce messages. They had recently held an "awards ceremony" for staff in order to emphasise their priorities for the service. They told us this had gone down well with staff. It was another example of the manager's imaginative approach.

The registered manager actively sought feedback from their staff who had scored the quality of management at 4.6 to 4.8 out of five in a survey.

During the course of our inspection we asked to see a number of documents and files. The registered manager found them all promptly. They were all up to date, maintained and organised in a structured way. Information required for the management of the service was readily accessible.

The registered provider supported the registered manager and normally visited the service once a week and carried out audits and checks on the service. There was also a support network made up of other registered managers within the provider's organisation. They met regularly to share experiences and good practice, gave each other informal support and carried out peer audits of each other's services.

The registered manager sent a weekly written report to the provider. This covered occupancy, staff sickness, use of agency staff, staff training, accidents, and dependency levels of people living at the home. There was a free form section which was used to report any changes to the assessment of people's risk of poor nutrition and the status of any wounds being treated. This was reviewed by the registered provider who worked with the manager if any actions were indicated by the report.

Staff logged accidents and incidents. These logs were analysed to identify any trends, but there were none identified at the time of our visit.

The provider had a process for obtaining feedback about the quality of the service. Records showed surveys had

Good

Is the service well-led?

been sent to people, their families, staff, and health and social care professionals who visited the service. Surveys were returned to the provider's head office for analysis and compiling into a report. The registered manager had not received a recent report since the re-opening of the home after its refurbishment. The provider had produced a report of "Company Testimonials" which contained positive comments about the home by people and their families.

There was a system of internal and external checks and audits to monitor and assess the standard of service provided. The registered provider and registered manager both carried out unannounced spot checks on aspects of the service. An example of these was a spot check on a meal. This included whether the food was in line with the published menu, whether it was ready on time, and whether it was presented in an appetising way.

External checks included a review of the management of medicines by the provider's pharmacist and a mattress audit. A fire risk assessment was carried out by the provider's own specialist staff.

A sample of people's care plans were audited every month. There was a monthly audit of changes to people's weight and the progress of any people with or at risk of wounds such as dry skin, skin tears or skin infections. Changes to people's care plans and changes to the information provided to catering staff resulted from these audits.

Other internal checks included checks on mattresses, bed rails, cleaning, the administration and storage of medicines, meals, and kitchen hygiene. There were daily checks on the cleaning schedule, and a monthly cleaning audit. Audits of medicines included daily checks on medicine records, monthly checks on the administration of skin creams and ointments, and checks on the disposal of unused medicines. Where these checks identified actions, the responsible staff member confirmed in writing that the action had been completed.

Regular checks carried out included a dignity audit. This was a two stage process consisting of a self-assessment by the staff member and a review by the registered manager. It included how the staff member promoted people's privacy, independence, individuality, self-esteem and confidence. It covered steps taken to avoid loneliness and isolation, and how the staff member engaged with people and encouraged them to share their experience of the service. The dignity audit was an example of how the provider encouraged staff to reflect on the service and identify strengths and areas for improvement.