Bupa Care Homes (ANS) Limited

Beacher Hall Care 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

Summary of findings

Overall summary

About the service
Beacher Hall Care Home provides residential nursing care for younger people with acquired brain injuries and some older people. The service can provide accommodation with personal care for up to 70 people. At the time of our inspection there were 67 people living in the home.
Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service

We found that people were safe care because their risks were managed effectively. Risk assessments demonstrated that people's identified risks had been assessed and were being managed safely and reviewed regularly. We found that medicines were administered safely, and records demonstrated that people has received their medicines as prescribed. Staff medication training competency were up to date. Required learning was identified from accidents and near misses.
People's needs were assessed regularly, reviewed and updated. People, relatives and professionals consistently told us the staff delivered care in accordance with their assessed needs. People were supported by well trained staff.
People experienced positive relationships with staff who treated them with kindness in their day-to-day care. Staff consistently treated people with dignity and respect and maintained their privacy.
People experienced person-centred care. Care plans were personalised and contained lots of detail around people's interests and preferences. People had access to activities and the necessary support to follow their interests
The registered manager, deputy manager and staff consistently placed people at the heart of the service and clearly demonstrated the caring values and ethos of the service. The quality of the service was monitored through robust clinical governance processes. The service had built up working relationships with community partners.
The home was undergoing a refurbishment programme at the time of our inspection. Further improvements were needed. Bathrooms were in the process of being updated at the time of inspection. There were some mixed views from staff about the approachability of the management team, but the management had put actions into place to improve this. They had introduced anonymous feedback forms for staff to complete.
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Rating at the last inspection
At the last inspection the service was rated Good (published 2 December 2016).

Why we inspected

This was a planned inspection based on the previous rating.

Follow up
We did not identify any concerns at this inspection. We will therefore aim to re-inspect this service within the published time scale for services rated good. We will continue to monitor the service through the information we receive.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our effective findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our effective findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our effective findings below.

Beacher Hall Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector, one inspection manager and an assistant inspector.

Service and service type
Beacher Hall Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The service had a manager registered with CQC. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information the registered manager sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We reviewed the notifications received from the provider, since the last inspection. The law requires providers to send us notifications about certain events that happen during the running of a service.

During the inspection
We spoke with five people who used the service and four relatives. We also spoke with the registered manager, the deputy manager, the lead physiotherapist, one nurse, two care staff, two activity coordinators and the chef. We also spoke with two student nurses and six visiting health and social care professionals. We

observed medicines being administered and the support people received in communal areas, including the preparation and consumption of meals.
We reviewed six care records and medicine administration records (MAR).We looked at six staff recruitment files, together with the provider's training schedules. We also examined other documents relating to the management of the service, procedures, quality assurance audits, team and relative and residents meeting minutes and satisfaction surveys.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at service policies. We spoke with professionals to gain feedback.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question remained good.

Good: People were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse
● Effective systems were in place to safeguard people from harm and abuse. All recorded safeguarding concerns had been reported to the appropriate authorities.
● People were protected from the risk of abuse because staff had the necessary safeguarding training and understood their role and responsibilities to safeguard people, including how to report concerns internally and to external bodies. One member of staff told us "If I was concerned about anything I would immediately report it to my manager". When concerns had been raised, the management team carried out thorough investigations, in partnership with local safeguarding bodies.
● People, their families and staff told us they felt the service was safe. One person told us, "The staff are second to none and we are well looked after."

Assessing risk, safety monitoring and management
● People experienced safe care because their risks were managed effectively. Risk assessments demonstrated that people's identified risks had been assessed and were being managed safely and reviewed regularly. For example, people had management plans to protect them from the risks of falls, moving and handling and developing pressure areas. Staff knew people's individual risks and how to support them safely to reduce these risks.
However, we did note that some interventions to manage risk needed to be better clarified in people's care plans, for example; some people had the intervention of being repositioned every four to six hours. There were not always repositioning charts in place and therefore it was not clear if these actions had been undertaken. When discussing this with the management team and clinical staff we were told that repositioning charts were not required in all cases as people could move themselves. They agreed that this needed to be made clearer in the care plans.
● People's individual emergency evacuation plans were in place and accurately reflected their needs.
● There was a clear system in place to investigate accidents and incidents. For example, when people experienced a fall, an investigation would take place, which included completing a falls diary, additional plan of care and updating risk assessments.
● A choking risk assessment was carried out to determine people's risks involved when eating and drinking. For example, the risk assessment clearly stated the level of assistance people would need.
● People were protected from environmental risks within the home, which had been assessed and measures taken to minimise those risks. For example, hot water temperature checks.
● There was a ten at ten handover each morning attended by all heads of areas and a handover each morning and evening on all three floors. At these meeting staff were fully informed of any changes to

people's needs.

Staffing and recruitment
●People were supported by sufficient numbers of staff.
● Staff told us there were enough staff deployed to meet people's needs safely. However, some staff did tell us that they would like more time to spend with people in meaningful ways. For example, one staff member, when asked if they thought there were enough staff, stated, "To be honest I would say no because we're busy, but I think the residents are happy"
● The registered manager stated he would be using a provider rotating software system which staff members could access at any time. This tool calculated the amount of staff required based on the assessed needs of the residents.
● We observed that people had their care needs met in a timely way.
● People were protected from the risk of being supported by unsuitable staff. The provider had completed relevant pre-employment checks to make sure staff had the appropriate skills and character to support older people and those living with dementia. These included prospective staff's conduct in previous care roles and their right to work in the UK.
● All new staff members were required to complete a four-day class roomed based induction course, which covered the care certificate, before they worked with people.
● Relatives felt there were enough staff to meet the needs of people living at the home.

Using medicines safely
● People had their medicines managed safely.
● Staff were trained to administer medicines safely and their competency to do so was checked regularly.
● Records demonstrated that people had received their medicines as prescribed, in a way they preferred, in line with their medicine management plans.
● Staff supported people to take their medicines in a respectful way. Staff ensured that people's dignity was maintained when administering medication. People were asked if they were ready for their medicines and were given time to take them.
● Medicines were stored and disposed of safely, as required by legislation.
● Where people had medicines prn 'as required', for example for pain, there were clear protocols for their use. These were updated and reviewed regularly.
● Staff accurately completed Medicines Administration Records (MAR). The MAR charts provided a record of which medicines were prescribed to a person and when they were given.
● There were weekly medicine audits undertaken by the nursing staff on each floor, as well as more detailed monthly medicine audits. Both of which highlighted any issue or concerns in a timely way and had clear actions to address deficiencies and outcomes.

Preventing and controlling infection
● People and relatives consistently told us the home was kept clean.
● Staff were trained in the prevention and control of infections.
● We saw that the home was clean and free of malodour throughout the duration of our inspection.
● Personal protective equipment was available for staff, such as disposable gloves to use to help the spread of infection.

Learning lessons when things go wrong.
● All accidents and incidents were recorded and reviewed daily by the management team.
● The registered manager and clinical nurse managers took prompt action to implement the required

learning identified from accidents and near misses. For example, lessons had been shared with staff to improve safety across relevant parts of the service in relation to medicine errors and falls management.
● Where one person had fallen eight times, a 'falls pattern' was identified. This identifiable information was then fed down through clinical management meetings to staff members and the risk assessment updated.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

At the last inspection this key question was rated as good. At this inspection this key question remained good.

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● We saw that there were comprehensive pre-admission assessments in place to make sure the service understood and were able to meet people's health, care and medical needs.
● People's assessments were person-centred and considered all aspects of their lives.
● People and relatives told us staff had the necessary skills and expertise to meet people's complex needs. One relative told us, "yes staff are trained, there is a nice variety of staff, the physio staff are brilliant."
● All people had a communication plan which clearly outlined their likes/dislikes and what they can do for themselves.
● People's needs were assessed regularly, reviewed and updated. People had detailed care plans, which promoted their independence and opportunities to maximise their potential.
● People and their relatives told us they had been actively involved in creating and developing their care plans.
● People, relatives and professionals consistently told us the staff delivered care in accordance with their assessed needs and guidance within their care plans, which we observed during the inspection.

Staff support: induction, training, skills and experience
● People were supported by well trained staff. Staff training at time of inspection was at 97% and up to date at the time of the inspection.
● Staff told us that they felt well supported and that they had regular supervisions and appraisals.
● New staff received a thorough induction that provided them with the necessary skills and confidence to carry out their role effectively.
● The training staff received was linked to the Care Certificate. The Care Certificate sets out national outcomes, competences and standards of care that care workers are expected to achieve.

Supporting people to eat and drink enough to maintain a balanced diet
● We observed staff made mealtimes an enjoyable and sociable experience, with friendly chat and discrete support when required. People told us they enjoyed the food, for example one person told us, "'Yeah,… there's good choices of food…"
However, there were occasions where the interactions could be more person centred;we did observe some staff not explain what they were about to do.
● For example, one staff member took a person's plate away without asking permission. We discussed this

with the manager who said they would remind staff of the importance of ensuring people were asked permission before undertaking any activity.
● The service followed a four-week menu.
● The registered manager told us that they had recently brought some new dining equipment following feedback from professionals, to improve people's dining experience.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support
● Staff worked with GPs, specialist therapists and specialist nurses to make sure care and treatment met people's needs.
● Staff made prompt referrals to relevant healthcare services to ensure people's needs were met.
● A visiting healthcare professional told us, "'If there's anything I do hear I'll feed it back. Generally, people are really happy."
● The registered manager told us about partnership working with dieticians. They describedhow a dietician had visited the service to do training with the kitchen staff and reviewed all care plans to ensure they met the needs of people with specific dietary requirements.

Adapting service, design, decoration to meet people's needs
● The home was undergoing a refurbishment programme at the time of our inspection. Further improvements were needed for example, signage on bathroom doors. People were involved in decisions about the decoration of their rooms, which met their personal and cultural needs and preferences.
● Nurse stations were located on each floor where nurses could be made aware of what was happening on the floor.
● There was a computer room where people could use the internet and contact their families.
● The service had a gym on the second floor that was specially adapted to help people who lived there.
● There was an accessible, enclosed garden which people appreciated.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards. We found the service was working within the principles of the MCA, any restrictions on people's liberty had been authorised and conditions on most authorisations were being met. We did fond one example where a condition was not fully being met however when this was brought to the management team's attention they assured us it would be rectified.
● People's human rights were protected by staff who demonstrated a clear understanding of consent, mental capacity and Deprivation of Liberty Safeguards legislation and guidance.
● We observed staff seeking consent from people using straightforward questions and giving them time to respond. Staff supported people to make as many decisions as possible. One staff member told us "We always give people choices and help them to make their own decisions if we can".
● Records showed us that there was a clear process in place to ensure mental capacity assessments and best interest decisions were in place and reviewed on a regular basis. For example, around the use of bed rails or lap straps when in a wheel chair.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question remained good.

Good: People were supported and treated with dignity and respect; and involved as partners their care.

Ensuring people are well treated and supported; equality and diversity
- Staff offered support that was caring and compassionate.
- People experienced positive relationships with staff who treated them with kindness in their day-to-day care. One person told us "They [staff] are very, very nice".
- Where people had needs arising from their social or religious background, such as food preferences, these were met.
- Whilst it was not always clear from people's care plans regarding how people's equality and diversity needs were being met. On speaking with staff, we were assured that they were considered.
- Staff and people provided examples where support was given to meet the diverse needs of people, including those related to sexuality and faith.
- The service had a resident's community meeting, which is a group of residents, which one of them would chair. There was a manifesto for changes they would like. This was then fed back to the registered manager.

- The service undertook monthly relative meetings and used customer feedback forms to gain feedback.

Supporting people to express their views and be involved in making decisions about their care
- People and relatives were actively involved in their care and support decisions to the extent they wanted to be.
- Care plans were developed with people, their relatives, where appropriate, relevant health and social care professionals and by the staff team who knew them well.
- Care plans and risk assessments were reviewed regularly, which allowed people to make sure they accurately reflected their current needs and preferences.
- People's views on how the service was run and the support they received was regularly sought.

Respecting and promoting people's privacy, dignity and independence
- Staff consistently treated people with dignity and respect and maintained their privacy.
- On several occasions we observed staff discretely support people to maintain their personal dignity.
- During our inspection, we saw that all staff spoke in a respectful manner with people.
- Staff described how they supported people to maintain their privacy. They told us they made sure doors and curtains were closed and people remained covered during support with their personal care. A light was used outside each person's door as a sign care was in progress. We saw staff utilise this light and not enter

when it was lit.

● The provider had appropriate systems in place to protect people's confidential information, whilst ensuring this was readily available to those authorised to view it.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

At the last inspection this key question was rated as good. At this inspection this key question remained good.

Good: This meant people's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● People experienced person-centred care. Care plans were personalised and contained lots of detail around people's interests and preferences. People and their families were involved in the planning of their care and support needs.
● We did query the use of some health checks that appeared to be in place for everyone without any record of a rationale or evidence of a person-centred approach. The reason for its use was explained to us but it was agreed that each person should have their needs individually assessed with a rationale for the health check usage.
● The provider effectively identified and met people's communication needs so they could understand information, including information about their service.
● Arranging accessible means of communication that were individual to the person showed an awareness of legal obligations around communication needs.

Supporting people to develop and maintain relationships to avoid social isolation
● People had access to activities and the necessary support to follow their interests. The service had four activities coordinators who were passionate about helping to provide people with meaningful activities and live a more fulfilling life. We saw that activities were linked with people's individual interests, for example, one person enjoyed playing bingo, whilst another enjoyed watching horse racing. Records of all activities were in place and the impact of these on people, including how much people enjoyed a specific activity was evaluated and changes made if needed. Those people who were supported in bed or who didn't want to join in with group activities were given regular one to one time. For example, activities coordinators would provide support such as reading books, hand massages, and looking through photo albums, depending on what the person enjoyed.
● The registered manager told us that they recently had an open day BBQ for St Georges Day with a singer that people and their families could attend as a social occasion.
One person told us, regarding their activities, "'I do art... I've got my paintings on the wall here, and in the corridor"
● One relative told us, "Nobody wants to be in a care home, but if you are, this is the one to be in. They [staff] are like family to people".

Improving care quality in response to complaints or concerns
● Complaints were managed robustly and in a timely way. The registered manager used the learning from concerns and complaints as an opportunity for improvement. For example, a staggered meal time routine

had been introduced. However, relatives and people had raised a concern that they didn't like this approach and therefore the meal times were changed back to a set time.

● People and relative told us they would feel confident raising a concern or complaint.

● The registered manager told us they used a datix system to handle complaints which they tracked as a part of their quality assurance process and were then reviewed by their head office.

End of life care and support

● The registered manager told us people with end of life care preferences were recorded in their individual care plans, with family involvement when needed.

● Staff receive training on end of life care. The registered manager told us the care team have provided training to staff as well.

Good

Is the service well-led?

Our findings

Well-Led - this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question remained good.

Good: The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- There were effective management systems in place to promote person-centred care.
- The registered manager, deputy manager and staff consistently placed people at the heart of the service and clearly demonstrated the caring values and ethos of the service.
- There were some mixed views from staff about the approachability of the management team. One staff member told us "Yes I would go to the manager if I had any concerns" another staff member said "Some people say he's not approachable…"
- The registered manager, who had only been with the service since February, told us they were aware of this issue and were trying to promote an open and inclusive culture. This included an hour every week where they and the deputy manager would make themselves available for staff to come to them with any concerns or feedback. The registered manager would then look at putting in actions regarding the feedback. One staff member stated, "…anything that's said to them they do action."
- People experienced high quality care from a staff team who were committed to ensuring they received care which was individual to them.
- Staff understood people's needs and preferences, recognised the importance of knowing people well and could share details about people with us.
- The management team understood their Duty of Candour, to be open and honest when things went wrong.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was a clearly defined management structure within the service.
- The registered manager, deputy manager and staff understood their individual roles and responsibilities, and the importance of working together to achieve the best outcomes for people.
- The quality of the service was monitored through robust clinical governance processes. For example, a clinical audit was carried out daily during a walk round, there were weekly meal service audits and clinical risk meetings. Monthly audits were carried out on first impressions of the home and file auditing, which was carried out by different people to ensure that there were 'fresh eyes' to undertake them. Quarterly audits were completed on infection control and health and safety. The registered manager told us, "If there are any issues picked up, this would then be fed into the service quality improvement plan."

● Staff communicated effectively with each other in relation to people's changing needs and moods, to ensure they always received appropriate care and support.
● The registered manager was aware of their responsibilities to report significant events to CQC and other agencies. Notifications had been received in a timely manner which meant that the CQC could check that appropriate action had been taken.
● A professional told us regarding the leadership of the service, "Every floor has a nurse in charge who is very knowledgeable as to what is happening on their floor. There is also [staff member] who seems to know the 'ins and outs' of all the residents, which is amazing and very helpful for the weekly GP ward round."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We observed the management team were highly visible within the service and approachable.
● People's and relative's views were listened to and acted upon. Residents and relatives' meetings were held jointly. Staff put up monthly 'you said, we did' posters so people could clearly see what had been put into place. For people who cannot attend meetings, the activities team go through the events of the meeting on a one to one basis.
● The registered manager told us he had introduced team building exercises into team meetings to help with communication and team working, and also a Friday coffee morning with management and anonymous staff feedback forms.
● A relative told us, "They [the management team] are always gaining feedback and wanting to know and act on this straight away and are helpful with questions and advice."

Continuous learning and improving care
● The provider had suitable arrangements to support the registered manager, for example through regular meetings with the provider's regional director, which also formed part of their quality assurance process.
● Staff recorded accidents and incidents, which were reviewed daily by the management team and provider.

● The registered manager effectively assessed and monitored action plans, to ensure identified improvements to people's care were implemented.

Working in partnership with others
● The service was keen to involve the local community. For example, they had relationships with Reading Blue Coat School, the Prince's Trust and the University of London. The registered manager told us they provided work experience and university placements.
● The registered manager and staff worked effectively with the wider multi-disciplinary team of health professionals to improve the outcomes for people
● The provider's annual 'Open Day' was scheduled to take place this summer. Members of the community were invited to this event, such as the Mayor and each year had a different theme. This year we were told it would be an arts and crafts theme.