Beaumont Lodge Limited

Beaumont Lodge Nursing Home

Inspection report

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Date of inspection visit:
27 September 2016
28 September 2016

Date of publication:
01 November 2016

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

This inspection took place on 27 and 28 September 2016. The inspection was undertaken by one inspector and a specialist advisor, and was unannounced. At our previous inspection on 24 October 2013 we found the provider was meeting the regulations in relation to outcomes we inspected.

Beaumont Lodge is a nursing home located in Camberley in the county of Surrey. The home is registered to provide accommodation and support for up to 43 people and specialises in providing nursing care for the elderly. At the time of our inspection 43 people were using the service.

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 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.

People using the service said they felt safe and that staff treated them well. Their privacy and dignity was respected by staff. Safeguarding adult's procedures were robust and staff understood how to safeguard the people they supported. Staff told us they sought consent from people when offering them support. The registered manager demonstrated a clear understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

There were enough staff to meet people's needs and appropriate recruitment checks took place before they started work. There was a whistle-blowing procedure available and staff said they would use it if they needed to.

Risks to people using the service were assessed; care plans and risk assessments provided clear information and guidance for staff on how to support people with their needs. People and their relatives [where appropriate] had been involved in planning for their care needs. People were supported to maintain a balanced diet, and had access to a range of healthcare professionals when required. People received appropriate end of life care and support.

Regular residents and relatives meetings were held so that people could talk to the registered manager and provider about the home and things that were important to them. The provider took into account the views of people using the service and their relatives and staff through surveys, and took action to make improvements to the service in response to the feedback. There was a range of appropriate activities available to people using the service to enjoy. People knew about the home's complaints procedure and said they were confident their complaints would be fully investigated and action taken if necessary.

Staff said they enjoyed working at the home; they received appropriate training and good support from the registered manager. Unannounced spot checks, including weekend and night time checks, were carried out by the provider and registered manager to make sure people received good quality care at all times.

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.

Medicines were managed safely and records showed that people were receiving their medicines as prescribed by health care professionals.

Appropriate procedures were in place to support people where risks to their health and welfare had been identified.

There were arrangements in place to deal with foreseeable emergencies.

There were appropriate safeguarding adult's procedures in place. Staff were aware of the action to take if they had safeguarding concerns.

There were enough staff on duty to meet people's needs. Appropriate recruitment checks took place before staff started work.

Is the service effective?

Good

The service was effective.

Staff had completed an induction when they started work and received training relevant to the needs of people using the service.

The provider was creative in looking at ways to support people to eat and drink sufficient for their needs, and to protect against the risks of inadequate nutrition and dehydration.

Staff sought consent from people when offering them support. The registered manager and staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and acted according to this legislation.

People had access to a GP and other health care professionals when they needed it.

Is the service caring?

Good

The service was caring.

Staff spoke to people in a respectful and dignified manner.

People's privacy and dignity were respected.

People and their relatives, where appropriate, were consulted about and involved in developing their care plans.

There were arrangements in place to meet people's end of life care needs.

Records including medicines records were held securely and confidentially.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed. Care and treatment was planned and delivered in line with their individual care plan.

People were provided with a range of appropriate activities.

People using the service and their relatives knew about the home's complaints procedure. and said they were confident their complaints would be fully investigated and action taken if necessary.

Is the service well-led?

Good

The service was well-led.

There were appropriate arrangements in place for monitoring the quality and safety of the service that people received.

Staff said they enjoyed working at the home and they received good support from the provider, registered manager and senior staff. There was an out of hours on call system in operation that ensured that management support and advice was available to staff when they needed it.

The manager and provider carried out unannounced night time and weekend checks at the home to make sure people were receiving appropriate care and support.

Beaumont Lodge Nursing Home

Detailed findings

Background to this inspection

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

This unannounced inspection was carried out on the 27 and 28 September 2016. The inspection team on the first day consisted of one inspector. The inspector returned to the home on the second day together with a specialist adviser who was a senior nurse.

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 improvements they plan to make. We looked at this information together with other information we held about the home including notifications they had sent us. A notification is information about important events that the service is required to send us by law.

We spent time observing the care and support being delivered. We spoke with eight people using the service, five visiting relatives, six members of staff, the provider, the registered manager and the home's clinical lead. We looked at records, including the care records of seven people using the service, five staff members' recruitment and training records and records relating to the management of the service. We also spoke with health care professionals and the local authority responsible for commissioning the service, and asked them their views about the home.

Not everyone at the service was able to communicate their views to us so we also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People told us that they felt safe and were well treated. One person said, "I feel safe here. All my needs are met and the specialist sees me when needed." A relative said, "I am happy that my relative is safe and contented. The home is excellent and the staff are wonderful. Even I feel like I'm part of the family." A health care professional said, "Excellent quality nursing care."

There were systems in place to ensure that people consistently received their medicines as prescribed by health care professionals. Medicines were stored in a designated medicines room which could only be accessed staff responsible for administering medicines. The medication room temperatures and medicines fridge temperatures were monitored and recorded and we noted that they fell within safe ranges. The medicines fridge was locked and sharps bins did not contain inappropriate items.

We observed medicines being administered to people on the second day of the inspection and saw that staff sought their permission was sought before medicine was administered and that people were gently encouraged to take their medicine. We checked the balances of medicines stored in the medicine room against people's Medicines Administration Records (MAR) and found these records were up to date and accurate. The MAR also included a photograph of the person, as well as details of their known allergies and details of staff members authorised to administer medicines. This helped reduce the risks associated with medicines administration.

The MAR showed that people were receiving their medicines when they needed them and any reasons for not administering medicines was recorded. We saw up to date protocols were in place to advise staff when and under what circumstances people should receive any medicines that had been prescribed 'as required'. Staff told us what they would do when people required an 'as required' medicine. They also told us what they would do if a person missed their medicines and how they would report any safety incidents.

Action had been taken to support people where risks had been identified. People's care files included a wide range of risk assessments in areas including falls, moving and handling, medicines, weight loss, nutritional needs, continence care and skin integrity. People also had individualised risk assessments on behaviours that may challenge and their medical conditions and these provided guidance to staff on how they should support people so that the risk to them could be minimised. For example, where people were assessed as being at risk of malnutrition, there were plans in place to support them with eating and drinking. In another example, where people were at risk of falls we saw records confirming staff had been monitoring their safety on a regular basis.

We saw examples of how the MUST risk assessment tool was completed in order to identify a person's risk of malnutrition. MUST is a Malnutrition Universal Screening Tool and is a five step screening tool used to identify adults who are malnourished or at risk of being undernourished. One person's risk assessment score placed them at high risk of malnutrition and we saw steps had been taken to refer the person to a health care professional who provided them with prescribed diet supplements.

There were arrangements in place to deal with foreseeable emergencies. People had personal emergency evacuation plans (PEEPS) which highlighted the level of support they required to evacuate the building safely. Staff we spoke with knew what to do in the event of a fire. They told us there were regular fire drills so they were reminded about their roles in such an event. Records confirmed that staff received regular training on fire safety. The home had a fire safety audit conducted by the Surrey Fire and Rescue Service in June 2015 which advised that there were no significant issues found. We saw records confirming that the fire alarm was tested on a weekly basis, regular fire drills had been carried out and that evacuation drills occurred every six months.

Records of accidents and incidents were maintained that contained information about each incident and any action that had been taken. For example a review of a person's risk assessment, or the making a GP referral. This helped reduce the risks of similar incidents occurring in future.

There were policies and procedures in place to protect people using the service from the risks of abuse and avoidable harm. The registered manager and staff we spoke with demonstrated a clear understanding of the types of abuse that could occur and the signs they would look for. They were also aware of the action to take if they thought someone was at risk of abuse including whom they would report any safeguarding concerns to. Records confirmed that the registered manager and all staff had received training on safeguarding adults from abuse. A member of staff said, "I wouldn't hesitate in reporting any concerns and escalating that concern if I thought the home were not doing enough about it. Thankfully I have never had cause to make a report but am confident the home would act properly if I did. Resident safety is really important here."

Thorough recruitment checks were carried out before staff started working at the home. We looked at the personnel files of five members of staff that worked at the home. The files contained completed application forms that included references to their previous health and social care experience, their qualifications and their full employment history. Each file included two employment references, health declarations, proof of identification and evidence that criminal record checks had been obtained for all staff to ensure their suitability for their roles.

People using the service and staff told us there were always enough staff around to meet their needs. During the inspection we observed a good staff presence. Staff were attentive to people's needs and when people required assistance they responded quickly to provide support to people. One person using the service said, "There are always enough staff around. You don't have to wait too long when you need them." A relative said, "There are always staff around and someone on hand to speak to." The registered manager told us that staffing levels were arranged according to the needs of the people using the service. If people's needs changed, additional staff cover was arranged. The provider did not employ bank or agency staff and we noted that they had a sufficient number of permanent full and part time staff to cover rotas, including staff sickness and annual leave. This meant that there was always enough staff to meet people's needs and that staff were familiar with people and how best to provide support.

Good

Is the service effective?

Our findings

People using the service said staff and the manager knew them well and how best to support them. Relatives and visitors told us that staff were skilled at meeting the needs of people at the service, and were competent in supporting them with their complex conditions. They spoke highly about the care and support at the home. One relative told us, "We are really happy our relative is here. Their condition has improved since admission and in just three months they are a different person." A health care professional also commented, "The whole team certainly meet people's needs. They know their patients very well and quickly recognise any deterioration and act on it in the patient's best interests."

People were supported to eat and drink sufficient quantities to maintain a balanced diet and ensure their well-being. Care plans identified people's nutritional needs and preferences, and how they could be supported by staff to eat a nutritious and healthy diet. For example, one person's care plan recorded that they needed encouragement to drink. Where concerns were identified relating to people's nutritional intake or weight loss we saw that referrals were made to the GP for advice and support.

We observed a mealtime during the inspection and saw that people received plenty to eat and drink. Staff were available to offer support to people where required and we observed them gently encouraging people to eat in a relaxed an unhurried manner. We saw that one person was supported to cut their food. Most people ate together and appeared to enjoy the mealtime but people were also able to eat in their own rooms if they preferred. One person using the service said, "No complaints. I really enjoy the meals. It's restaurant quality." Another person told us, "I think there is enough choice and you get asked about what you would like."

The chef told us they spoke with people about their meal preferences. They were aware of people's dietary requirements and received daily notifications from staff that included details of people's weights and any changes to their condition. They said, "I am aware of residents' requirements and the need to ensure they are properly nourished and hydrated. If a resident's weight is decreasing I fortify food with extra cream and if someone is having problems with swallowing we know how to mash or change the consistency of food so people are safe."

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager demonstrated a clear understanding of the MCA and the DoLS. Staff we spoke with

were aware of the importance of seeking consent from people when offering support. They demonstrated an understanding of the MCA and how it applied to their roles. They said that some people using the service had capacity to make some decisions about their own care and treatment and others had varying levels of capacity. When there was a concern about capacity they said they would refer to the care plan. In the plans we saw that mental capacity assessments had been completed for specific decisions such as the use of bed rails at night time. Where a person had been assessed as not having capacity, records showed that relatives and health care professionals, where appropriate, had been involved in making the decision in their best interests. A health care professional said, "I know the home liaises well with professionals and next of kin when there are ever any issues." This meant that the provider had included views about people's care to ensure that the least restrictive option for care had been considered and that the MCA had been followed.

The registered manager told us that the home had made eight applications to the local authority to deprive people of their liberty. At the time of our inspection the local authority was processing all of these applications. We saw two of the applications and were satisfied that the home had raised them appropriately and in a timely manner.

Staff training records confirmed that all staff had completed training in areas the provider considered mandatory. Mandatory training included safeguarding adults, the MCA and DoLS, dementia awareness, health and safety, moving and handling, infection control, first aid and fire safety. Some staff had also completed training on other topics such as administering medicines, end of life care, and nutrition and hydration. Mandatory training was recorded and the records indicated when staff required training updates. This was monitored by the provider and action taken if necessary to ensure staff remained up to date with their training requirements. Most staff had completed accredited qualifications relevant to their roles within the home. For example, care staff had completed qualifications in health and social care, and kitchen staff had qualifications relating to food and hygiene. Nursing staff had also completed training relevant to their roles.

Staff told us they had completed an induction, which was confirmed by the records we reviewed. One member of staff said, "I can remember the induction as being quite involved and I wasn't allowed to work on my own until I had passed competency tests. The training is regular and wide ranging."

Staff told us, and records confirmed, that they received a supervision session with the registered manager every four weeks and an annual appraisal of their work performance. They said this helped them in providing the care and support to people using the service, and that they felt well supported by the registered manager. One member of staff told us, "Senior staff and the clinical leads are always available. I can approach them whenever there is an issue or a situation I have not come across before."

We found that people were supported to maintain good health. Records showed that people had access to a range of healthcare professionals including a GP, optician, chiropodist, and dentist. Staff also supported people to attend hospital appointments. In one case we found that a referral had been made to a specialist wound expert following identification that an injury was not healing and that the person and their relatives had been kept informed of the process throughout. Records and advice to staff about the process of referring matters to nursing staff at the home and, as required, to external professionals was documented in the care records and on the person's care plan.

Feedback about the service from healthcare professionals was positive. One healthcare professional told us, "Staff are well trained and professional." Another said, "They call on us appropriately and are skilled at recognising a deterioration in people's condition and in so doing avoiding unnecessary hospital admissions."

Good

Is the service caring?

Our findings

People said that staff were caring. One person told us, "I love my carers and the nurses are wonderful. I know they care for us all." A relative said, "The care and support they provide is first rate." A visiting health care professional told us, "They care about their residents' emotional well-being as well as their physical health needs." Another said, "I have seen staff treat people with respect and courtesy. They have a very caring and professional attitude."

People were involved in their care and support plans and where this was not possible it was noted that relatives were actively involved. For example a number of relatives also told us they were consulted about their relatives' care and support needs especially when things changed. One relative said, "I have seen my relative today and staff took time out to meet with us both to discuss the GP's new prescription and how the home were going to monitor the effectiveness of the new drugs."

If people could not express their view the service ensured that the person's relative was involved. We noted that on the occasions when relatives or other supporters were unavailable, people had access to a professional representative who acted as an advocate. An advocate is a specially trained person who can help support people if they do not have capacity to make particular decisions.

All of the care files we looked at included a section on personal histories. This recorded the person's hobbies and interests, details of significant events and favourite places, and the jobs they used to do. A health care professional said, "Staff are always cheerful and are actually interested in their patients and their life and interests."

When looking at the care plans we saw that end of life care plans and consent forms requiring the person's agreement regarding their care and treatment were in place.

During the inspection we noted that staff knew people well and understood their needs. We saw examples of good care and saw that people were treated with understanding, compassion and dignity. Staff actively listened to people and encouraged them to communicate their needs. For example, we observed a member of staff joining in and assisting a person to tell a humorous story to their relative about an incident on a day trip. We also saw staff responding to people's needs in a calm caring manner supporting them with everyday tasks and responding to requests for drinks and snacks.

Staff knocked on people's doors requesting permission to enter when they were present. One person said, "Staff always knock and call my name when I'm in my room." Where people needed support with personal care, staff ensured their privacy by drawing curtains and shutting doors. Staff told us they tried to maintain people's privacy, dignity and independence as much as possible by supporting them to manage as many aspects of their care that they could. They said that they explained what they were doing and sought permission to carry out personal care tasks. They told us they offered people choices, for example, with the clothes they wanted to wear or the food they wanted to eat. One member of staff said, "I always respect privacy and dignity and never do anything that could embarrass people. I treat people as I'd like to be

treated." Another said, "I call people by their preferred name and take my time with people."

Staff said they made sure information about people was kept locked away so that confidentiality was maintained at all times. We saw that all personal documentation including care plans and medicines records were locked away in the main office and this meant that only authorised staff accessed people's records.

If people could not express their view it was noted that the service ensured that the person's relative was involved. On the occasions when relatives or other supporters were unavailable it was noted that people using the service had access to a professional representative who acted as an advocate. This person is a specially trained advocate who can help if a person does not have capacity to make particular decisions.

People were provided with appropriate information about the home in the form of a service user guide. This guide ensured people were aware of the standard of care to expect, details of access to health care professionals, the service's complaints procedure and information about the service and facilities provided at the home.

Good

Is the service responsive?

Our findings

People were supported to engage in a range of activities. One relative we spoke with said, "There's lots to do and all manner of outside activities. I am encouraged to join in and always feel welcomed when I do." A healthcare professional said, "Whenever I visit I am always impressed with the activities and how people are encouraged to participate."

Activities on offer at the service included going out for pub lunches, and trips to garden centres and to historic sites. During the first morning of the inspection we saw some people participating in a residents meeting whilst others were sitting quietly reading newspapers and some people watching television. During the afternoon we saw the home's activities coordinator engaged with people in a quiz. People participated enthusiastically whilst staff gave encouragement or offered appropriate support. The activities co-ordinator also told us that the home celebrated people's birthdays and that they were currently preparing one person's 100th birthday celebrations.

Throughout the course of our inspection we saw positive interactions between people using the service and staff. The activities co-ordinator said, "I get good support from the provider and manager to provide activities. I do one to ones with people who cannot leave their room and, where I can, involve the residents in planning activities. We all loved getting out in the garden during the summer and are busy planning our autumn activities that will include a harvest celebration."

People's care files were well-organised, easy to read and accessible to staff. We saw that people's healthcare and support needs were assessed before they moved into the home. These assessments covered areas including, moving and handling, mobility, nutrition, communication, sleeping, emotional and spiritual needs, activities, medicines, continence and end of life care. The home's clinical lead told us that care plans were developed using the assessment information and kept under regular review. They contained information about people's medical and physical needs. For example, one person's care plan included information about a person's susceptibility to pressure sores and how the risk could be mitigated by using a special mattress and a routine of repositioning.

Care plans also included information such as how people liked to be addressed, their likes and dislikes, details about their personal history, their hobbies, pastimes and interests and guidance to staff about how their care and support needs should be met. For example, one person's care plan advised staff to speak to the person loudly and clearly, as they were hard of hearing. Each person's care file included a care plan summary sheet, a copy of which was located in their room. This provided staff with an 'at a glance' summary of the persons care and support needs, their personal history and likes and dislikes.

People's care files also included risk assessments and other documentation, for example, Mental Capacity Act (2005), Deprivation of Liberty Safeguards assessments and records of best interests decisions. We also saw Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) forms, where appropriate, in the care files. The DNAR is a legal order that tells a medical team not to perform Cardio-pulmonary Resuscitation on a patient. However this does not affect other medical treatments. These had been fully completed, involving people

using the service, and their relatives, where appropriate and signed by their GP. All of the care plans and risk assessments we looked at had been reviewed on a monthly basis or more frequently if required to ensure they were reflective or people's current needs. We also saw daily notes that recorded the care and support delivered to people.

Records showed that people and their relatives were also involved in an annual review of care planning. Views from people and relatives were recorded and confirmed their agreement to the care plan. The clinical lead at the home showed us a daily handover sheet used at the home. They said this ensured people received continuity of care. A member of staff confirmed there were hand over meetings where they shared any immediate changes to people's needs. They said that these meetings were also used to make sure that all of the care staff were aware of any new admissions and their care needs.

The provider had a complaints procedure in place that was included in the service user guide. It told people how to complain, who to contact and what would happen. People said they knew about the complaints procedure and told us they would tell staff or the registered manager if they were not happy, or if they needed to make a complaint. One person said, "If I'm not happy I know what to do and am sure that I will be listened to and action taken."

Relatives also said they knew how to make a complaint if they needed to. They said they were confident they would be listened to and their complaints would be fully investigated. The provider maintained a complaints file that included a copy of the complaint's procedure and forms for recording and responding to complaints. The records showed that there had been one complaint in 2016 that had been investigated and responded to appropriately.

Good

Is the service well-led?

Our findings

A visiting health care professional said, "The home is well run. Everyone seems to work effectively and they act quickly on issues. They achieve really good outcomes for the people in their care." Another said, "The home is managed by qualified staff and meets the needs of residents."

The registered manager and provider had undertaken a range of audits in relation to areas of the service including health and safety, cleaning schedules, fire checks and quality assurance records. We saw action had been taken in response to audit findings. For example, where an issue with the recording of the administration of people's medicines had been identified during a medicines audit, the clinical lead at the service had spoken to the member of staff in question to ensure that medicine had been administered as prescribed and also used this as an occasion to check the member of staff's competency. We also saw records from an external pharmacist also audited the home's medicine's stock, storage and administration records annually.

Regular unannounced checks had been made by senior staff during evening shifts, and the provider also made visits to the home at weekends and conducted checks of the home's cleanliness. Where issues had been identified, we noted that appropriate changes had been made. For example, a night-time check had identified the potential for windows to be left open in the main lounge where they were causing drafts for people, so a schedule of checks by care staff had been implemented.

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Staff told us they liked working at the home and praised the support they received from the senior staff, provider and manager. We saw minutes from a staff meeting in August 2016 that showed that staff were able to raise issues with the provider and as a result a different shift pattern was introduced to ensure cover at busy periods. There was an out of hours on call system in operation that ensured that management support and advice was always available to them when they needed it. One staff member told us, "There is really good communication between carers and nursing staff. We are all one big team. I know that I can always raise problems with nurses or the manager." A healthcare professional said, "Senior staff lead from the front. A really well run home."

The provider took into account the views of people using the service and their relatives about the quality of care provided at the home through surveys. The registered manager said they used feedback from the surveys to make improvements at the home. A residents and relatives survey had been carried out in May 2016 and we noted that action had been taken in response to the feedback received. For example, changes had been made to the location of a trip away from the home in response to survey findings.

People told us that they attended monthly resident meetings to discuss aspects of the service and how improvements could be made to the running of the home. We observed a meeting that was being held and saw that people participated enthusiastically, were listened to by senior staff and encouraged to air their views. People discussed issues with the laundry, food preparation and new entertainment performers they would like to visit the home. After the meeting one person said, "We get to ask what we want and what we'd like to change. More often than not things get changed."