Berrystead Nursing and Residential Home Limited

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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

Berrystead Nursing and Residential Home provides accommodation, personal care and nursing care for up to 46 older people. The accommodation is on two floors of a converted building. There was a choice of communal areas including a conservatory. There were 32 people using the service at the time of this inspection.

This unannounced inspection took place on 19 October 2017.

At our last inspection on 20 September 2016 we found that improvements were required in the management of people's medicines and quality monitoring were not effective. At this inspection we found that the improvements had been made.

The service had a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff understood their responsibilities to protect people from abuse and avoidable harm. Staff knew how to recognise the signs of abuse and what action to take should they suspect it. People felt safe and able to raise any concerns they may have. Risk was assessed and managed. People's freedom to make choices and take risks was respected.

Most people felt that there were sufficient numbers of staff on duty to meet people's needs. Staffing numbers were calculated based on the dependency levels of people who used the service and these were monitored. Checks were carried out before staff were offered employment so that so far as possible only staff with the right skills and characteristics were employed.

People received their prescribed medicines in a safe way. The receipt, administration and disposal of medicines was recorded so that staff could check and monitor the management of people's medicines. Medicines were stored safely and securely.

Staff received the training and support they required to meet people's needs. Induction and on-going training was based on up to date and 'best practice' guidance. Staff consulted with other professionals and authorities for advice and further training where this was required. People had access to the healthcare support they required such as physiotherapists, doctors and nurses. People had enough to eat and drink. Staff and catering staff understood people's dietary needs and how to meet them.

Staff sought people's consent before providing care and support. People had their capacity to make decisions assessed. Where people had their liberty deprived in order to keep them safe, this was only done

with assessment and authorisation from the local authority team. The registered manager had identified shortfalls in the recording of mental capacity assessments and best interest decisions and had arranged for staff to receive further training about this.

Staff were caring and compassionate. Staff knew people well and had developed positive relationships. They knew about the things that were important to people and how best to communicate and provide emotional support. People were able to make choices and were involved in planning and reviewing their care and support needs. People had their privacy and dignity maintained and independence was encouraged.

People had their needs assessed before they moved into the service. Important information about people's unique social history and cultural needs was recorded so that staff could provide care that was personalised. There was a range of social and recreational activities on offer. People were able to pursue their hobbies and interests.

People knew how to make a complaint and felt that they would be listened to and action would be taken. Complaints were recorded along with the action taken.

People and staff felt supported and included by the management team. Meetings were held and satisfaction surveys were used to gather feedback and make improvements. There were effective quality monitoring systems in place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe and staff understood their responsibilities to protect people from abuse and avoidable harm.

Risk was assessed and risk management plans were in place.

There were sufficient numbers of staff with the right experience, skills and character.

People's medicines were managed in a safe way.

Is the service effective?

Good

The service was effective.

People were cared for by staff who received the training and support they required to meet their needs.

People were asked for their consent before staff provided care and support. People had their mental capacity to make decisions assessed. Further training for staff about the recording of mental capacity assessments and best interest decisions had been arranged.

People had enough to eat and drink and enjoyed their meals.

People had access to the healthcare services they required. Staff knew how to recognise deteriorating health.

Is the service caring?

Good

The service was caring.

People had developed positive and caring relationships with staff.

People were supported to express their views and make decisions.

People had their privacy and dignity respected.

Is the service responsive?

Good

The service was responsive.

People received care that was personalised. There was a wide and varied range of social and recreational activities on offer.

Complaints were investigated and used to learn and improve.

Is the service well-led?

Good

The service was well led.

People and staff were supported by managers who were open and inclusive.

The quality of service provision was checked and monitored.

People and staff were involved in developing the service.

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Detailed findings

Background to this inspection

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

This inspection took place on 19 October 2017 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience caring for a person living with dementia.

Before the inspection, we asked the provider to complete 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 previous inspection reports, information received and statutory notifications. A notification is information about important events and the provider is required to send us this by law. We contacted commissioners who fund the care for some people and asked them for their views.

During the inspection we spoke with six people who used the service, nine visitors, the registered manager, five care staff and a qualified nurse. We considered information contained in some of the records held at the service. This included the care records for three people, staff training records, two staff recruitment files and other records kept by the registered manager as part of their management and auditing of the service.

Good

Is the service safe?

Our findings

At our last inspection 25 November 2017 we found that improvements were required in the management of people's medicines. Medicines were not always stored at the temperatures required by the manufacturer, records for medicine administration were not always filled in accurately and there were some delays in people having their medicine because the service had run out of stock.

At this inspection we found that improvements had been made.
Room temperature and medicine fridge temperatures were checked daily and records showed that temperatures where within the required range for safe storage. Medicines where stored securely and records of administration were accurate and up to date. Records of medicines received into the service and those returned to pharmacy were also maintained. This meant there was a clear audit trail and staff could check that medicines were being administered correctly. Audits were carried out every month and records showed that safe policies and procedures were being followed. All staff responsible for managing people's medicines had their competency checked. We saw that action was taken to address any shortfalls in the safe management of people's medicines.

People told us they felt safe. A visitor said about their relative "They are happy and safe". Staff knew how to recognise the signs of abuse and understood their responsibilities to protect people from abuse and avoidable harm. Staff knew how to report concerns and who to report them to. The registered manager told us about the action they had taken in response to concerns and this was appropriate.

Staff knew what action to take in the event of an accident or incident. Risk was assessed and management plans were in place to reduce risk. For example, if a person was assessed as being at risk of developing a pressure sore, specialist equipment was provided and care plans instructed staff about how to reduce risk such as positional changes. People also had their risk of falling assessed as well as the equipment they may require to help them move. We saw that staff assisted people to move in a safe and appropriate way.

Checks were carried out on the environment and equipment to make sure it was safe. Fire safety equipment such as fire alarms and emergency lighting were regularly checked. Staff had received training about fire safety and knew what action to take if the alarm sounded.

Most people said there were enough staff on duty, two visitors felt that there were not always enough staff and this meant their relative had to wait. Some staff said they were constantly busy but did not feel this affected the care and support people received. We spoke with the registered manager about how staffing levels and skill mix were calculated. We were told that a staffing tool based on people's dependency levels was used. A new call bell system had been fitted and this enabled staff to check how long the call bell had been ringing before staff attended. The registered manager told us they regularly checked this to ensure that people were not kept waiting for unreasonable amounts of time. A system of walkie talkies was also used by staff. This meant that staff could request assistance from their colleagues without having to leave the person to go and look for another member of staff. During our inspection we saw that staff were available and were assisting people when this was required.

We looked at recruitment files for two members of staff. Pre -employment checks and references had been obtained before staff were offered employment. This meant that so far as possible, only staff with the right characteristics and experience were employed. There were systems in place to continually check the professional identification numbers of the nurses employed to make sure they were registered with the nursing and midwifery council.

Good

Is the service effective?

Our findings

People who used the service and relatives had confidence in the staff supporting them. One person said "I consistently get good care here". A visitor said about the service "We think it's fantastic". Another visitor told us how their relative's wellbeing had improved since moving into the service. There were qualified nurses on duty at all times and staff received the training they required to carry out their roles and support people. A staff member said, "Training is very good, we are constantly being asked to attend more training".

Staff received induction training when they first began using the service. The 'care certificate' was used to provide induction training. This meant that new staff were trained to an identified set of standards designed for health and social care workers. Staff we spoke with confirmed they had received this training. They told us they had also spent time working with an experienced member of staff. Ongoing training was also provided and updated. The registered manager told us that all training was recorded electronically and training due or overdue was flagged up on this system. Records showed that staff had received the training they required. We saw that nurses had received additional training where this was required. For example, nurses had received training about how to manage specialist feeding tubes and catheters. Staff sought advice from other healthcare professionals and this was used to plan and deliver care and support. Staff also told us they received supervision from their line managers and were able to discuss their training and development needs.

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 decisions 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 procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

People were asked for their consent before staff carried out care and support. Staff explained how they communicated with people and offered choice such as the clothes they wanted to wear or where they wanted to spend their day. People and or their relatives had been involved in planning the care and support they required and this was recorded in their care plan. Staff knew and understood people's individual needs. The registered manager and staff we spoke with had received training about MCA and DoLS. This legislation protects people who lack mental capacity to make decisions about their care and who are or may become deprived of their liberty through the use of restraint, restriction of movement and control. Any restrictions must be authorised by a local authority. Some people had a DoLS authorisation in place and the registered manager told us that DoLS authorisations had been applied for but were still being assessed by the local authority. We spoke with a paid representative for one person who had a DoLS in place. A paid representative a is a person employed by the local authority to check that any restrictions are being applied in the correct way, They told us they were satisfied that staff were applying the DoLS in accordance with the person's care plan and in the less restrictive way. Some people's mental capacity assessments and decisions had not been clearly recorded in the care plan. The registered manager was aware of this and had booked

MCA and DoLS training for all staff to take place shortly after our inspection.

People were supported to eat and drink enough and maintain a balanced diet. A visitor told us "The food is very good, we join our relative for some meals like Christmas and Halloween". We observed the lunchtime meal and saw that the meals were well presented and people were supported appropriately. There was a calm relaxed atmosphere in the dining room. Some people preferred to eat in their room and this was respected. Staff and catering staff were aware of people's dietary needs, likes and dislikes. People had their risk of malnutrition assessed and action was taken where risk was identified. For example, some people had their meals fortified with milk and cream to provide additional calories. Some people could only eat soft foods and this was provided.

People had access to the healthcare services they required. Staff had consulted with other professionals such as doctors, physiotherapists and occupational therapists. Records showed that staff were following the advice given. For example, advice had been sought form a dietitian and this had been followed. Staff knew how to recognise people's deteriorating health. Qualified nurses checked people's observations such as blood pressure and pulse; they knew what action to take if the observations were outside of normal limits. Care staff also knew how to recognise that people were unwell. A member of the care staff told us they would report any changes such as appetite, skin changes or breathing changes to the nurse in charge. They were confident that the nurse would take appropriate action.

Good

Is the service caring?

Our findings

People said that staff were caring. Throughout our inspection we saw that staff knew how to communicate with people and people were relaxed and at ease. Staff knew people well and knew about the things that were important to them and how to offer reassurance when this was required. One person told us how much they easily became anxious and how staff spent time with them and made them feel better. They said ", "I have a named carer allocated to me now and we have a good rapport between us".

Staff cared about people's wellbeing. We observed whilst in the lounge area two carers approach a person who had fallen asleep in a recliner chair and slumped over, they carefully woke them and chatting to her assisted her into a more comfortable position. Records for one person showed that they had been in pain, staff had taken action and offered reassurance. Staff were proud and motivated about their jobs and told us how they provided people with emotional support. For example staff told us they spent time sitting with people and chatting to them, we saw that staff did this throughout our inspection. A care staff member told us "We have a good team, all the staff are compassionate". Another care staff member said "I love my job, people are looked after well".

People were involved in developing and reviewing their care plan. This meant that people were able to make decisions about the care and support they received. Care plans were focused on the person and recorded people's preferences. For example, care plans included people's preferred daily routines, one person preferred to have their door left open at night and this was respected. Another person liked to have their table with remote control and tissues next to them and accessible. People were asked if they could be cared for by male or female staff and this was also respected. Where people could not verbally express themselves, care plans informed staff about how to respond if the person became upset and anxious. People's visitors were made welcome and this helped people maintain relationships with the people that were important to them. Visitors said there were no restrictions for visiting times and they could see their relatives in private. One visitor said about the staff. "They will always talk to us, and they take care of my relative".

People had their privacy and dignity respected. The service had recently been awarded a silver dignity award from the local authority. Staff had received training about protecting people's privacy and had become 'dignity champions'. Records showed that this had been discussed with people at a 'resident's meeting and people were informed about the role of dignity champions. New signage had been introduced to alert staff and visitors not to enter people's rooms while they were receiving personal care. A member of the care staff told us how the dignity champion training had improved the quality of care for people by bringing dignity into focus. They said "It's a brilliant place to work, I feel confident people get the care that they need.

Staff were able to describe the ways they promoted people's privacy and dignity. For example, a member of the care staff told us how they kept people covered up as much as possible during personal care. They told us they would take care to speak quietly and confidentially when discussing people's needs with them. We saw that this was the case during our inspection staff spoke with people in a respectful way. While some of

the rooms could be used as shared rooms, the registered manager had taken the decision to only offer shared rooms to people who had specifically requested this. This meant that people had their own private accommodation.

Good

Is the service responsive?

Our findings

People received care and support that was responsive to their individual needs. One person told us how they had moved to Berrystead from another service. They told us that staff supported them in the way they preferred and they felt reassured by this. They had recently had their room redecorated and had chosen the colour scheme and wall paper. Staff knew people well and understood their needs. Staff we spoke with were able to describe how they met people's needs. For example, staff knew about the things that would cause people distress or anxiety and knew how to promote people's wellbeing. A member of care staff explained what the short term goals were for one person and how these would be achieved Information about each person's unique background and social and psychological needs was recorded. This was important so that staff could get to know people particularly if the person had difficulties communicating their needs.

Care plans were focused on the person and told staff how to meet people's needs in an individual way. For example, care plans informed staff about people's preferred daily routines such as what time they liked to go to bed and how they preferred to receive personal care. The most effective way to communicate was also recorded, for example where people had difficulties with speech, staff were told how best to approach them and assist them to communicate their needs. Records showed that staff worked in a flexible way in response to people's needs. For example some people liked to sleep late or have their meal at a different time and this was accommodated.
People's religious and social needs were also recorded. Staff supported people to worship in the way they preferred. Staff understood people's equality and diversity needs and respected these.

There was a full time activities co coordinator employed and a wide range of activities on offer. People told us about the things they did and how they enjoyed this. One visitor praised the activities co coordinator and told us how engaged in activities and stimulated their relative was .They told us how this had improved their relative's quality of life. We saw that a range of religious and other festivals were celebrated. There was a display board about Diwali (the Hindu festival of lights) which people had been involved in developing and making. Records and photographs showed that there was a constant and changing display focused on current events and changing seasons. This helped people to remain involved in the things that were important to them and to learn about other cultures. The activities organiser was able to describe how they used this and other activities assisted people to orientate themselves and to engage with staff about memories and important events they had lived through. People were consulted about the things they would like to do including trips outside of the home.

People using the service and visitors we spoke with told us they knew how to raise concerns and were comfortable about doing so. Staff also knew what action to take if someone had a complaint or concern. The provider had a complaints procedure which was given to people when they first moved into the service. Records were maintained about complaints received and the action taken to resolve them.

Good

Is the service well-led?

Our findings

At our last inspection on 20 September 2016 we found that some improvements were required because there had been a delay in taking action to address shortfalls identified as part of the audit and quality monitoring process. At this inspection we found that all of the action had been taken and that regular checks and audits were carried out and changes made to drive improvement. For example, an air conditioning unit had been installed so that the room temperature could be maintained within required limits for the storage of people's medicines. Staff had their competency to manage people's medicines checked and additional support and training was provided where this was required.

There was an on-going system of quality monitoring and checks were carried out to ensure that staff were following the provider's policies and procedures. Audits carried out included medicine records, nutrition and hydration and infection control. The registered manager carried out unannounced checks during the night to support the night staff. People who used the service were asked for their feedback during meetings. An annual satisfaction survey was sent out to people and the results of this were analysed and discussed at meetings. People were involved in the redecoration and refurbishment of the service. We saw that the majority of communal areas had been redecorated and people had their private rooms decorated to suit their individual needs and tastes.

Meetings were also held with heads of department and with the company directors. We saw that staff were able to give their feedback and ideas and that these were listened to. The use of walkie talkies was suggested by staff as a way to reduce the noise levels caused by staff using the call bell for a second carer. Staff also suggested the service held a charity coffee morning and this was arranged.

People and staff said the registered manager was supportive and accessible. One person said that the registered manager was 'wonderful'. We were told that the provider had also visited this person to offer reassurance and support. Staff also said the registered manager was supportive and approachable. They said they could talk to the registered manager about anything and they would listen. There was a shared culture and ethos between care staff and managers. Staff were clear about treating people as individuals and giving people choice. We saw that some people had complex and high dependency needs and staff worked flexibly to improve people's quality of life and accommodate their needs.

There was a clear organisational structure and staff understood their roles and responsibilities Policies and procedures were in place and staff knew about these and were supported to follow them. The registered manager was aware of their responsibilities to inform the Care Quality Commission (CQC) of incidents that may affect the service and did so.