Homebeech Limited

Homebeech

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 3 July 2017 and was unannounced.

Homebeech is situated close to the seafront in Bognor Regis and within walking distance of the town centre. Homebeech is registered to provide accommodation and nursing care for up to 66 people with a variety of health conditions, including dementia, physical disability and frailties of old age. At the time of our inspection, 48 people were living at the home. Homebeech is arranged into three units. The main part of the home called 'Oakside', but commonly referred to as 'Homebeech', supports people who have health care needs. Daffodil unit is for people under the age of 65 years who have a range of physical disabilities. Beechside unit is a secure unit that accommodates nine people living with dementia. The main part of the home comprises a large sitting room and dining room, with an adjacent conservatory. A further sitting room is available to people on the ground floor. The Beechside unit has separate facilities, including a lounge and dining area. All bedrooms have a toilet and sink ensuite. Accommodation is provided over three floors and lifts enable easy access. People have access to outdoor spaces.

In February 2016, we undertook a comprehensive inspection of this service and found breaches of regulations in relation to safe care and treatment, dignity and respect and person-centred care. We asked the provider to submit an action plan on how they would address these breaches. An action plan was submitted which identified the steps that would be taken. We undertook an unannounced comprehensive inspection of this service on 28 February and 30 March 2017. At the inspection we found that insufficient improvements had been made in relation to these three breaches of regulation. The service was rated as Requires Improvement in each domain and overall. As a result of our findings at the inspection, we took enforcement action and issued three Warning Notices on 4 April 2017, against each regulation, to the provider and to the registered manager.

Details of each breach were stated to the provider and registered manager in each Warning Notice. Regulation 12: Risks to people had not been identified or assessed adequately to ensure staff received guidance on how to support people safely. Records were not always reviewed consistently to ensure people's most up to date needs were met or communicated to staff. Premises were not always managed to keep people safe. Regulation 10: Not all staff displayed a caring attitude and several instances were observed when staff ignored people. Some people and relatives gave negative feedback about the care and support from staff. Regulation 9: Activities on offer to people had not been organised to reflect people's interests or to provide mental stimulation. Systems were not in place to ensure that records relating to people's care were accurate or contemporaneous.

We undertook this focused inspection to check whether these three regulations had been met. This report only covers our findings in relation to the topics written about in the preceding paragraph. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Homebeech on our website at www.cqc.org.uk

A registered manager was in post. 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.

Concerns relating to premises arising out of the last inspection had been addressed. However, at this inspection, maintenance staff working at the home had left the door to the boiler room unlocked and radiator covers were not affixed to walls, which meant that parts of the home were unsafe. Risk assessments had been improved and provided detailed information and guidance to staff about people's particular risks and how to mitigate them. Relatives felt their family members were safe living at Homebeech. Staff had been trained to recognise the signs of potential abuse and knew what action to take if they had any concerns.

Relatives talked about the caring nature of the staff at the home. Our observations at inspection demonstrated staff were kind and caring and positive relationships had been developed. Care staff were busy and did not always have time to sit and chat with people. There was no evidence to show how relatives and people were involved in planning their care.

No activities co-ordinator was in post and the registered manager told us they were in the process of recruiting to this post. Efforts had been made to provide meaningful activities for people, however, these were not always organised to reflect people's personal interests and hobbies; this was work in progress. Some external entertainers came into the home. Trips or outings into the community were not available and people had to rely on relatives or friends for visits out if they were unable to access the community independently. Staff had a lack of understanding of the concept of person-centred care.

We have made two recommendations to the provider as a result of our findings at this inspection. Improvements have been made and the requirements of the three Warning Notices have been met. However, further work is needed to sustain the improvements already implemented and to drive continuous improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Maintenance staff were working at the home and access to the boiler room was left unsecure. A fire escape door to an area of flat roofing was damaged, impeding access. Radiator covers were not affixed to walls because of ongoing work by maintenance staff.

People's risks had been identified and assessed appropriately. Guidance was in place to enable staff to support people safely. Staff had access to electronic care records.

Relatives and people felt the home was safe. Staff had been trained to recognise the signs of potential abuse and knew what action to take.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Staff were kind and caring with people, but did not always have time to sit and chat with them.

Records did not demonstrate how people or their relatives were involved in their care planning and review.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Work was underway to provide activities that reflected people's personal interests and preferences. At the time of the inspection, there was no activities co-ordinator, but this post was being recruited to.

There was a lack of personal histories within people's care plans to enable staff to have a comprehensive understanding about people's backgrounds and provide personalised care. However, staff had a good understanding of people and supported them in

a way that met their care needs.

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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.

We undertook this unannounced focused inspection on 3 July 2017. The team inspected the service against three of the five questions we ask about services: is the service safe, is the service caring and is the responsive?

This inspection was carried out to see whether the provider and registered manager had met the Warning Notices served under Section 29 of the Health and Social Care Act 2008.

The inspection was undertaken by two inspectors 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.

Prior to the inspection we reviewed the information we held about the service. This included the action plan sent to us by the provider which identified what actions would be taken and progress made against meeting the breaches of regulation. We also took account of the findings found at the previous inspection and which were the subject of the last inspection report.

We observed care and spoke with people and staff. We spent time looking at records including nine care records, records relating to activities provided to people and other records relating to the management of the service.

On the day of our inspection, we met with six people living at the service and spoke with two relatives. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, the provider's area manager and two care staff.

Requires Improvement

Is the service safe?

Our findings

At the inspection in February/March 2017, we found the provider was in breach of Regulation 12 - safe care and treatment. We issued a Warning Notice to the provider which required them to take action because risks to people had not been identified or assessed adequately to ensure staff received guidance on how to support people safely. Records were not always reviewed consistently to ensure people's most up to date needs were met or communicated to staff. Premises were not always managed to keep people safe. Following the inspection, the provider sent us an action plan which showed what steps would be taken to meet this regulation and the requirements of the Warning Notice. At this inspection, we found that sufficient improvements had been made and that the Warning Notice was met.

At the last inspection, we found that, although some improvements had been made, there were gaps in information relating to people's nutritional needs which meant that their risk of malnourishment was not monitored effectively. At this inspection, we looked at information in relation to people's risk of malnourishment, including the assessments which had been completed by using the Malnutrition Universal Screening Tool (MUST), a tool specifically designed for this purpose. We looked at MUST records which provided detailed information and guidance to staff on how to support people's nutritional needs. A 'MUST' folder contained nutrition action plans, the provider's policy on nutrition and hydration followed MUST guidelines and information included each person's needs at mealtimes, including their likes and dislikes. Each person's MUST assessment was reviewed monthly. Nutrition training had been arranged for staff and one staff member was a 'nutrition champion' and assisted in monitoring people's weights, advising the registered manager of any action that might be required.

We looked at risk assessments in relation to people's risk of choking, skin integrity, falls, moving and handling, bathing, continence, night care and personal care as these had been a concern at the last inspection. Where people had been identified as at high risk of falls, there was guidance for staff on when to seek advice from external professionals, for example, the local authority's falls team. People at risk of falls during the night were checked by staff at hourly intervals and records confirmed this. People's mobility needs were assessed appropriately, together with information about how staff should support people when they moved around the home. Where people had developed pressure areas or ulcers, their wounds were monitored and managed safely, with detailed information recorded on a wound chart. Equipment, such as pressure relieving mattresses and cushions, were in use where needed. Where people required bed rails to be in situ, to prevent them from falling out of bed, risk assessments had been drawn up. Where people lacked capacity to consent to the use of bed rails, best interest decisions were recorded appropriately. At the last inspection, care staff were unable to access the electronically stored risk assessments. At this inspection, all care staff had been provided with 'log-in' details on the provider's IT system and were able to access people's care records and risk assessments.

At the last inspection, premises were not always managed to keep people safe. Action had been taken to address the issues that were of concern. A trip hazard in the Beechside sitting room had been repaired. We had observed that a boiler room door on the first floor had not been kept locked, although a notice was affixed stating, 'Keep locked shut when not in use'. At this inspection we found that the door to the boiler

room had been left unlocked and that a cover had been removed near the boiler, exposing electrical wires. We also found that some radiator covers were not affixed securely. The bedhead to one person's bed was loose and rickety and the person told us they found it difficult to sleep, because the bedhead was not secure. We shared our concerns with the registered manager who told us that maintenance was underway to repair radiator covers and this was why covers were loose. Also, maintenance staff had been working on the boiler, although the registered manager agreed that the door should not have been left open. We observed that the general state of repair in the home, whilst safe, remained open to improvement. For example, carpeting in communal areas was stained and in need of replacement. We recommend that the provider assesses the risk whilst repair and refurbishment work is in progress.

Overall, sufficient improvements had been made and the requirements of the Warning Notice had been met.

We found the doors to a fire escape to a flat roof area on an upper floor were insecure and that a missing metal plate meant the plastic surround was being damaged by the door catch. The registered manager told us there was no-one living on that floor who could walk without assistance, so there was no risk of people going out of the fire door. They told us they would ask maintenance staff to fix the catch so it did not damage the door further. The premises were not purpose-built as a care home. The layout was such that it could present significant difficulties in evacuating people in the event of an emergency. The provider kept a Personal Emergency Evacuation Plan for each person living at the home. This outlined how people could be evacuated or kept safe in the event of an emergency, such as fire or flood.

Relatives we spoke with felt their family members were safe living at the home. One relative said, "[Named person] is very vulnerable, but the staff are lovely and keep them safe". Another relative told us, "It's much better since they've moved over to the dementia unit. The care was good in the main unit, but it's better and safer over here I feel". Staff members we spoke with had undertaken adult safeguarding training within the last year. They were able to identify types of abuse and understood the correct safeguarding procedures, should they suspect abuse. Staff were aware that a referral to an agency, such as the local Adult Services Safeguarding Team, should be made, in line with the provider's policy. Staff were also aware of the provider's whistleblowing policy. One staff member said, "I would let the manager know if I thought someone was being abused". Staff confirmed to us that the registered manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence.

Relatives we spoke with did not feel there were any restrictions placed on their family members' actions or movements. Referring to the Beechside unit, one relative said, "The unit is locked to prevent people with dementia getting out and coming to harm, but within the unit I think people come and go as they please". Our observations on the day confirmed this.

Requires Improvement

Is the service caring?

Our findings

At the inspection in February/March 2017, we found the provider was in breach of Regulation 10 - dignity and respect. We issued a Warning Notice to the provider which required them to take action because some staff did not display a caring attitude to people, in some instances, ignoring them. We observed an incident within the Beechside unit where staff did not treat people with dignity and respect. Care delivered by staff at the home was task orientated rather than person-centred. Following the inspection, the provider sent us an action plan which showed what steps would be taken to meet this regulation and the requirements of the Warning Notice. At this inspection, we found that sufficient improvements had been made and that the Warning Notice was met.

Relatives we spoke with told us the home was a caring place. One relative said, "The staff are caring, yes. Whenever I visit I'm made to feel welcome. Some staff are more caring than others, but there's no problem". Another relative told us, "I think the staff do a great job in difficult circumstances. They always show my relative kindness".

We observed care and support given to people throughout the day. Care was safe and appropriate with adequate numbers of staff present. We saw good interaction between people and staff, who consistently took care to ask permission before intervening or assisting people. There was a high level of engagement between people and staff and, where possible, people felt empowered to express their needs and receive appropriate care. It was evident throughout our observations that staff had enough skill and experience to manage situations as they arose; care given was of a consistently good standard. For example, people requiring assistance or encouragement at lunchtime were helped in a caring and discreet manner.

We observed a member of care staff supporting a person to eat their lunchtime meal. The staff member sat next to the person to cut up their food. The staff member spoke to the person all the time and watched their body language to ascertain their needs, since this person's verbal communication was limited. This interaction demonstrated that the member of staff had a good knowledge and understanding of this person's methods of communicating. We observed this staff member chatting with other people and care staff and these interactions meant that the lunchtime meal was a positive social experience for everyone. However, we also observed that some people had to wait for their lunchtime meal to be served. For example, people in their rooms had their meals served first. Others arrived in the dining room for their meal at about 12.15pm and were served, whilst other people who were also present had to wait until about 12.40pm. We observed that some people had to wait for their meal at our last inspection earlier in 2017. In the action plan, the provider stated that they were reviewing the lunchtime arrangements and considering the possibility of having two separate sittings for people. This would allow for meals to be served more quickly and mean people would not have to wait to eat. At the time of this inspection, the provider was still operating one sitting.

We spoke with one person who had a health concern and wanted to see their GP. We learned that this person was due to see their doctor the next day as an appointment had been arranged. However, the person was anxious and worried about a particular health issue and asked if we would ring their GP. We

talked with a member of care staff who said to the person, "You have a doctor's appointment tomorrow. Would you like me to ring and confirm the appointment time?" The person agreed to this and the care staff made the call to the surgery. The care staff was unable to obtain a response to their phone call, but told the person they would try again later. This was a good example of how this staff member responded promptly to the person's needs once they were aware of the issue.

Care staff were busy and did not always have individual time with people. However, care staff were on hand when needed. For example, we witnessed two people having a disagreement. Care staff moved one person to another table to sit with someone else. Later we found out that there were often heated exchanges between these two people, so staff knew how to de-escalate any potentially challenging situations.

We asked people and relatives whether they were happy with their level of involvement in care planning. A relative said, "The manager will always tell us if there are any changes. Their door is always open". However, we found no evidence in care plans that families had been formally involved in care planning and review. We recommend that the provider makes arrangements to involve people and/or their relatives in their care planning.

We observed staff interacting with people throughout the day. Staff were respectful and kind to people living at the home. We observed many instances of genuine warmth between staff and people. There was an inclusive atmosphere in the Beechside unit.

Requires Improvement

Is the service responsive?

Our findings

At the inspection in February/March 2017, we found the provider was in breach of Regulation 9 - person-centred care. We issued a Warning Notice to the provider which required them to take action because activities were not organised in a way that reflected people's interests, preferences or hobbies. On the first day of the inspection, some people who stayed in their rooms received no support from the activities co-ordinator who spent the day organising activities for people in a communal area. Records relating to what activities had been arranged for people on a 1:1 basis had not been completed since October 2016. Following the inspection, the provider sent us an action plan which showed what steps would be taken to meet this regulation and the requirements of the Warning Notice. At this inspection, we found improvements had been made and that the Warning Notice was met, although further work was still required to embed and sustain these improvements.

At this inspection, no activities co-ordinator was in post and the registered manager told us they were in the process of recruiting to this role. They said that, until the new activities co-ordinator was employed, an additional member of staff worked between 10am and 12 noon to support people with activities. Activities during the morning of our inspection were all individual, for example, jigsaw puzzles, painting and reading. Activities advertised at the home were arts and crafts twice a week, board and ball games, music, cooking and films. A gardening club was held every Wednesday during the afternoon. Some people had a member of staff with them for short periods to help them with the activity on offer. People were not involved in a group activity, so there was little or no social interaction amongst people. One person said, "We do Scrabble and quizzes". Another person told us, "We do exercises, but they are only light". We asked one person about any trips or outings on offer and they said, "We haven't had any for years. The last time was a trip to Arundel which got cancelled when the transport broke down. The care home used the fee to purchase a Chinese meal for everyone. There are no trips out". The registered manager told us that people did go out with their relatives but the home did not organise trips into the community.

Staff displayed a good understanding about the people they were caring for, for example, in their preferences for food and drink. However, they were unable to tell us significant details about people's personal and social histories. In addition, there were few care plans that contained personal or social histories relating to people. We asked staff how they found out about people's past lives with a view to providing person-centred care. One staff member could not tell us significant details about the personal histories of people they were looking after. Another staff member said they relied on care plans. We raised this issue with the registered manager who told us a large number of people living with dementia at the home could not recall their past lives and were without relatives who could assist. They agreed this was an area that needed to be addressed further.

We asked staff what they understood by the term, 'person-centred care'. None could tell us what was meant by the term. One staff member was able to tell us about the 'mum's test'. This phrase is used to describe whether someone would be happy for their relative to be placed in a care home, that is, that the care home would provide a good standard of care. We recommend that the provider refers to guidance on person-centred care to contribute to the care planning process.

We asked relatives about the provision of meaningful social, occupational and educational activities at the home. One relative told us, "There's nothing. I noticed they're playing nice music in here now, but it's usually the television". One staff member appeared in the morning with a castanet type musical instrument, encouraging people to use it or clap along. The relative said, "That's the first time I've seen that". Another relative, referring to their family member, said, "My relative wouldn't join in anyway, but I don't see much going on".

We asked staff about the activities on offer. One staff member said, "We do the best that we can with the time we have, but we can't do as much as we want". Another staff member was satisfied that people had proper access to meaningful occupations. They told us people had 1:1 time with staff and hand massages. However, they were unable to tell us of anything else regularly on offer to people. We observed many instances throughout the day where people were sitting alone for extended periods of time.

During the afternoon, an entertainer came in with some owls for people to see and pet. Staff had cameras so they could take pictures of the event. The provider's area manager told us, "We have an organised activity every two weeks, there's always something going on". The registered manager showed us some records which they were in the process of collating. These records, entitled 'All about me', had identified people's personal interests and hobbies and the registered manager said this would be the start of ensuring activities were organised in a person-centred way. People were supported with their spiritual needs, for example, with receiving Holy Communion.

We looked at a range of care plans which were held electronically. These provided detailed information about people and advice to staff on how to support people.