Healthcare Homes Group Limited

Beaumont Park Nursing and Residential 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

We carried out an unannounced inspection on 09 August 2017.

At the last inspection in June 2016 we found the service was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing levels and supervision, safe care and treatment, consent to care and good governance. We also had concerns about the impact on people of sharing a bedroom, particularly when the person had not been asked for their consent, or they lacked the capacity to give their informed consent. At this inspection we found the service was meeting the expected standards and was no longer in breach of the Regulations. The provider had reduced the number of shared bedrooms from nine to two, and these were occupied by people who had consented or stated a preference to share.

The service provides accommodation and nursing or personal care for up to 46 adults, some of whom may be living with dementia and/or with life limiting conditions. At the time of the inspection, 38 people were being supported by the service.

The service had a registered manager. 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.

There were systems in place to safeguard people from harm and staff understood when and how to report any concerns they had to the appropriate authorities. There were risk assessments in place that gave guidance to staff on how risks to people could be minimised.

The numbers of staff on duty were sufficient to maintain people's safety, although staff reported being rushed at times. The manager was regularly reviewing this so that enough staff were available should the numbers of people using the service increase or their needs changed significantly. The provider had effective recruitment processes in place.

Staff received regular supervision and appraisal. They had been trained to meet people's individual needs and understood their roles and responsibilities to seek people's consent prior to care being provided. The requirements of the Mental Capacity Act 2005 were met.

People were supported to have enough to eat and drink, and to maintain a diet that was suited to their needs. The manager was taking appropriate action to deal with comments that some people would have preferred more choice of meals and some told us the quality of the food was not always good. People were also supported to access other health and social care services when required.

Staff were kind and caring and most people were happy living at the service. People's dignity and privacy were protected and they were supported to make choices and maintain their independence.

People's needs had been assessed, and care plans took account of people's individual needs. There was a range of events and activities provided and people were supported to maintain links with the local community. However a few people felt that the activities provided did not satisfy their interests, although they had not been receptive to the manager's attempts to improve their experience.

The provider had a formal process for handling complaints and concerns.

The service sought feedback from people and acted on the comments received to improve the quality of the service. The provider had systems in place to monitor the quality of the service and the manager had an effective system for auditing each aspect of the service to ensure that management oversight was effective. However, further work was necessary to ensure that people's experiences were consistently positive about staffing levels, food and opportunities for them to pursue their hobbies and interests.

Staff felt supported by the manager and had a good understanding of their roles and responsibilities.

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 there were systems in place to safeguard them from harm.

Risks to people were assessed and measures were put in place to minimise them whilst also maintaining their independence. Up to date emergency evacuation plans were in place.

There were robust recruitment systems in place and there were sufficient staff on duty to keep people safe, although this would need to be reviewed should people's needs change or the numbers of people living at the service increase.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had sufficient knowledge and skills to meet people's needs.

Staff understood their responsibility to ask people for their consent before providing care and the requirements of the Mental Capacity Act 2005 were met.

People had enough to eat and drink and were supported to have their health care needs met.

Is the service caring?

Good

The service was caring.

People were supported by staff that were kind, caring and friendly.

Staff understood people's individual needs and they respected their choices.

Staff respected and protected people's privacy and dignity. The numbers of shared bedrooms had reduced from nine at the last

inspection, to two. These were occupied by people who had consented or stated a preference to share.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans were in place which were person centred and documented people's individual needs.

People confirmed their individual needs were met and that they and their family members had been consulted during the development of their care plan.

People were supported to pursue their hobbies and interests, and although some people felt this provision could be improved, we saw that the manager had taken steps to offer a wide variety of alternative pastimes to people.

There was an effective complaints system in place

Is the service well-led?

Good

The service was well-led.

There was a registered manager in post.

The manager promoted a person centred culture within the home and staff understood their roles and responsibilities when supporting people in meeting their needs.

People who used the service and their relatives were able to share their experiences of the service and these were used to drive continuous improvements.

Quality monitoring audits were carried out regularly by the home manager, which were reviewed by senior managers, and the findings were used to drive improvements. Regular provider monitoring visits were carried out to ensure that action required to make improvements was carried out as necessary.

Beaumont Park Nursing and Residential 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 inspection took place on 09 August 2017 and was unannounced. The inspection team was made up of 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.

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 also reviewed information we held about the service, including the notifications they had sent us. A notification is information about important events which the provider is required to send to us.

During the inspection, we spoke with 12 people who used the service, four relatives and friends, the registered manager, the deputy manager, who was also a nurse and the clinical lead for the service, the business manager, a regional manager responsible for overseeing the management of the service, a nurse, and five care staff.

We looked at the care records for six people who used the service, the recruitment and supervision records for four staff and the training records for all the staff employed by the service. We also reviewed information on how the provider handled complaints and how they managed, assessed and monitored the quality of the service.

Good

Is the service safe?

Our findings

At the last inspection in June 2016 we found that there were not always enough staff on duty to meet people's needs safely. People told us they had to wait an unacceptably long time for assistance and that staff were rushed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection we found improvements had been made although some people told us they still waited a long time for assistance on occasion. One person said, "Call bells are answered eventually. Sometimes it is 20 minutes or more if it's a busy time. There are not enough staff, they are overworked and have no time to do it all." Another person said, "The buzzer is answered in a few minutes. Sometimes staff are busy but I've never felt worried. There are always people about to look after me." However, evidence from call bell audits showed that in recent months, people did not wait long to be supported by staff. We also observed that call bells were answered quickly during the inspection.

Staff we spoke with were concerned that there was not always enough staff in the morning to support people with personal care. They all said that they struggled to support people promptly in the morning. One member of staff said, "Lately, we have been short of staff and not able to provide the best care. Six staff is enough, but one extra staff makes all the difference as some residents need extra support." Another member of staff said, "There is sometimes not enough staff in morning as this is our busiest time. We definitely work better with seven staff." Another member of staff said, "Mostly we have enough staff, but there are odd days when staff go off sick. Although we can just about manage with six staff in the morning, it makes a real difference with seven." We looked at the staff rota for the previous two weeks and found that, on most occasions there were seven staff scheduled to work in the mornings and only a few occasions where this number dropped to six. The manager explained that, ideally, seven staff would be on shift in the morning. However, due to the reduction in the numbers of people living at the service, cover was only arranged if the number of staff fell below six as this was sufficient to meet the needs of the people currently using the service. They confirmed that, should the number of people or their needs increase, the staff numbers would be recalculated to take account of this.

On the day of the inspection, although staff were busy, we observed that people's needs were met quickly. We saw that the manager frequently reassessed the staffing levels in the service to ensure that people's needs could be met. This was done using a dependency tool which calculated the number of staff required based on people's individual needs. In conjunction with this, the manager also reviewed accidents, incidents, and falls to ensure that the calculations were an accurate reflection of people's current needs. We concluded that enough staff were on shift to meet people's needs safely.

At the last inspection in June 2016 the service did not have an up to date evacuation plan setting out how each person was to be supported to evacuate the building in the event of a fire or other emergency. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made.

Each person had an up to date evacuation plan in their personal records detailing their support needs in

relation to evacuating the building. This was accompanied by an up to date list of the person's medicines to ensure they received the right medical care if they were accommodated elsewhere in the event of an emergency. A copy of each person's evacuation plan was also in their room and held centrally within a contingency plan bag.

Most people told us they felt safe living at the home. One person said, "Yes (I feel safe)" A relative said, "Safe? Yes (I feel it's safe), and [family member] is well looked after."

The provider had up to date policies designed to protect people from abuse which included safeguarding and whistleblowing. Staff told us people were safe and they confirmed that they had been trained on how to safeguard people. They were able to describe actions they would take if they were concerned about people's safety including a member of staff who told us that they would always report concerns to the manager. One member of staff also said, "Residents are safe because we do things properly, but I worry a bit about some staff who get flustered and rush a bit while supporting residents as this could cause accidents." They told us that they had provided support to these members of staff and we advised that they spoke with the manager about arranging formal support and training for them. Another member of staff told us that people were safe and they had never been concerned about possible abuse or neglect by staff. They further said, "That's never crossed my mind once." A third member of staff said, "I have never seen anyone being abusive to anybody. If I had, I would definitely say something." Another member of staff said, "Residents are safe and there are no abuse issues. No-one can do that really because they know that everyone else is watching them."

There were personalised risk assessments for each person to monitor and give guidance to staff on any specific areas where people were more at risk. Staff knew about people's risk assessments and none of them were concerned about the quality of these. One member of staff told us that as much as possible, they made sure that people were safe, although unforeseen incidents did occur at times. They gave us an example of a person who was at risk of falling because they at times tried to walk unsupported. They added, "We can make them as safe as we can really." There were risk assessments in people's care records in relation to fire risk, nutrition, pressure areas, and mobility including those for people supported to move by staff. Where bed rails were in use there were risk assessments in place to support this. The assessments maintained a balance between minimising risks to people and promoting their independence and choice. They had been reviewed and updated regularly or when people's needs had changed so that people received the care they required.

We saw that there were processes in place to manage risk in connection with the operation of the home. These covered all areas of the home management, such as fire risk assessment, water temperatures, prevention of legionnaire's disease and electrical appliance testing. Regular fire drills were carried out to ensure staff knew how to respond in the event of a fire. The manager had ensured these were done at different times of day and covered different scenarios to test staff's understanding. For example a recent early morning fire drill had taken place where staff were told that the fire involved the ignition of a flammable substance resulting in a person being at risk of harm. This was done to test staff's knowledge of how to respond to a fire involving Oxygen tanks which were currently held at the service.

We saw that robust recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home. We looked at four staff files and found that appropriate checks had been undertaken before staff began work at the home. These included written references, and satisfactory Disclosure and Barring Service clearance (DBS). Evidence of their identity had been obtained and checked, and there was a clear record of the employees previous work experience and skills.

People's medicines were managed safely because there were systems in place for ordering, recording, storing, auditing, and returning unrequired medicines to the pharmacy. Medicines were administered by nurses and care staff applied topical creams to people and this was recorded on a separate record. We reviewed the medicine administration records for 15 people and saw that these were completed correctly, with no unexplained gaps. The nurses we spoke with told us that they had no concerns about how people's medicines were managed and that they worked effectively with the doctors who prescribed the medicines and the pharmacy that supplied the medicines so that people always had the medicines they required. They also had a system to check medicine stocks so that any medicines about run out were replaced in a timely way. There was guidance on how nurses should manage 'as and when required' (PRN) medicines and the guidance on specific home remedies had been signed by a doctor. There were care plans for managing short-term treatments such as when people were prescribed antibiotics to treat infections.

Good

Is the service effective?

Our findings

At the last inspection in June 2016 staff had not had regular supervision or annual appraisals. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection improvements had been made. Staff told us they were supported well by the nurses and the manager, and that they received regular supervision. One member of staff said, "I get regular supervision and my next one is a bit overdue now because of leave. My supervisor is good at arranging this though." Another member of staff said, "I get supervision and I have no issues with that." A third member of staff told us, "Supervisions are good and helpful. I feel really supported."

People told us that staff supported them well and in a way that met their individual needs. One person told us, "The regular staff are well trained." When asked if they provided good quality care to people, one member of staff said, "We all try our best to support residents well."

The provider had an induction and a regular training programme for all staff in a range of subjects relevant to their roles. These included moving and handling, fire safety, infection control, and dementia awareness. The training records we saw showed that the majority of staff training was up to date and the manager had booked training for those staff who needed it. Staff were complimentary about the quality of the training which enabled them to have the skills and knowledge to support people effectively. One member of staff said, "In-house training is good and helpful, but I struggle a bit with online training. You take it in more when you have someone in front of you." Another member of staff told us, "Training has been good, but sometimes I feel I need refresher training more often for some things like fire safety." Members of staff who were fairly new to the service were happy with the induction training they had received, with two of them telling us that this was over a period of four days.

The Mental Capacity Act (MCA) 2005 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.

At the last inspection in June 2016 we found that, although some capacity assessments had been carried out where it was thought that people may lack the capacity to make decisions for themselves, the assessments had been generic rather than decision specific as required by the MCA. We also found that capacity assessments had not always been carried out where it would have been appropriate to do so, such as when bedrails were in place or when a decision was made to accommodate a person in a shared bedroom. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) regulations 2014.

At this inspection we found that improvements had been made. Capacity assessments we looked at had been appropriately carried out and best interest decisions made were recorded. The provider had made the decision that shared bedrooms were only to be offered to people who were able to give their informed

consent to this. Where people shared bedrooms, there were now appropriate records in place to show that they had capacity to make a decision to share a bedroom with a person they were not related to. This was periodically reviewed to ensure that people remained happy to share a bedroom.

There were signed consent forms in each person's care records including for care and treatment, and for photographs being taken by the service for identity and clinical purposes. Staff told us that they always asked for people's consent before supporting them including one member of staff who said, "I always make sure that the residents are happy for me to help them."

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). We saw that the provider had taken appropriate steps to refer people for assessment if the way their care was provided could result in their liberty being restricted.

People had enough to eat and drink although some people did not feel the quality and variety of food was sufficient. One person said, "The food is very basic. There is plenty of it but it's boring. The same veg all the time. I don't care if I never see another carrot." Another person said, "(The food) is like school dinners." However, another person said, "The food is good." When asked their opinion about the food provided, a relative said, "It's good. I sometimes finish what [family member] doesn't want."

On the day of the inspection, lunchtime in the dining room was pleasant and relaxed. Tables were set attractively with paper napkins, silk flowers and clean table cloths. The menu was written on a whiteboard. Water was available on the tables and, although there was no juice or squash offered, one person had a glass of red wine. The menu provided a rather limited choice of food and staff we spoke with said that this needed to be reviewed so that people had a variety of food to choose from. Three staff told us that, at times, the kitchen staff were not flexible when asked to prepare alternative food for people who did not like what was on the menu. One of them described a specific cook as being "rude and grumpy" when staff asked if something else could be prepared for a person who might not have wanted anything on the menu. However, one person we spoke with told us, "I think they would bring a salad if I asked (for something different)." All care staff we spoke with said that the quality of the food was mainly good and that they ate the food too when they worked a long day. We discussed the concerns about the quality and variety of food with the manager who told us about how they had been working with the cooks to increase the food options available to people. Menus were being continuously reviewed following regular consultation with people to seek their views and suggestions.

Care records showed that people's weight was monitored regularly and referrals were sent to dietitians if there were concerns about a person not eating enough to maintain their health and wellbeing. There was evidence that where required, the provider worked closely with other professionals such as GPs, opticians, dietitians, chiropodists, and community mental health teams so that people's needs were appropriately met.

Good

Is the service caring?

Our findings

We noted that the provider and the registered manager had taken significant steps to reduce the number of shared bedrooms in the service. At the last inspection in June 2016 there were 18 people sharing nine bedrooms within the service. Each person's space was divided by a curtain which did not afford people adequate privacy to have conversations or personal care without being overheard. People who were unwell or at the end of their life did not have privacy. At this inspection the number of people sharing had reduced to four sharing two bedrooms, each of whom had made an informed choice to do so. There was a room available for people to move to if unwell in order to maintain their privacy and dignity, as well as that of the person they shared with. This was a significant improvement to the arrangements in the service for maintaining people's privacy and dignity.

People told us most staff were kind and caring. One person said, "Most are good, have a sense of humour. They listen and do what they can." Another person told us, "Care staff chat and are very good." One relative spoke about a member of staff they felt had been particularly good. They said, "[Staff member] is so kind and has the right attitude." They went on to explain that their relative was happy to be assisted with personal care by this member of staff despite usually having a preference for support from a member of staff of a different gender. This was because the member of staff put them at ease and provided sensitive and person centred care.

Although people told us that most staff were caring, some people told us there were exceptions to this and they each made reference to the same very small number of staff who they alleged were unkind, did not care and ignored people if they complained about them. We discussed these matters with the manager who was aware of these issues and was managing the performance of the staff concerned appropriately and with confidentiality.

During the inspection, we saw people were at ease in the company of staff and that conversations were cheerful, compassionate and not restricted to discussions about care tasks. Staff were respectful and friendly when addressing people. We saw they knew people well and chatted warmly to them throughout our visit.

Staff understood the need to promote people's rights to make choices about how they lived their lives. They further told us that people made decisions about other aspects of their care including choosing what they wanted to wear, eat or do to occupy their day. Staff viewed it as their role to enable people to remain as independent as possible, with one member of staff explaining how they would help people to use their skills as much as possible when supporting them with personal care. One member of staff also said that this promoted people's self-esteem.

Staff worked hard to maintain people's dignity and privacy, working discretely when supporting people with personal care, ensuring doors were closed and that discussion about personal matters was kept as private as possible. One person told us, "They knock, close the door, and close the curtains." Staff told us that they always treated people with respect and promoted their privacy and dignity. One member of staff said, "I

have never seen anyone not being respectful to the residents. Everyone is treated with dignity here." Another member of staff said, "We are respectful and we always provide personal care in private."

Information about the service was given to people when they came to live at the home to enable them to make informed choices and decisions. Some people's relatives acted as their advocates to ensure that they understood the information given to them. People told us that visitors were welcome at any time and relatives we spoke with confirmed they were made to feel welcome. One relative said, "It (the home) feels nice when you come in."

Good

Is the service responsive?

Our findings

An initial assessment was carried out when people first came to the service to determine their level of need and from this a care plan was developed. The provider had introduced a new care planning system and the manager was in the process of updating the care plans for every person living at the service. The new format care plans we looked at were detailed and person centred, giving staff sufficient information to understand the individual's needs and preferences. They covered people's identified needs in relation to areas such as eating and drinking, personal care, sleeping, pain management, skincare, mobility, communication and activities of living. There was evidence that people had been involved in this process.

Staff said they were familiar with people's care plans as they had read them to ensure they knew how to support people safely and effectively. Each person had a named nurse and key worker. Care staff confirmed that they were key workers for some people and said the benefit of this was that they got to know a small group of people really well as they were expected to spend some time helping them with issues they needed support with. We saw that nurses reviewed and updated care plans regularly to ensure they were appropriate to people's current needs.

There was a weekly activity plan displayed in communal areas which showed that a range of activities including bingo, word games, lunch at a local church, manicures and pamper sessions were planned for that week. On the day of the inspection, a visiting entertainer facilitated a singalong session during the afternoon. In the morning we saw staff assisting a group of people with some knitting. We saw from records that a number of seasonal events were planned throughout the year, such as Christmas, Halloween and Guy Fawkes themed events.

Although there appeared to be a wide range of activities provided, four people told us they did not feel their interests were provided for. One person said, "(Activities) are so boring, nothing to do. There is bingo and quizzes but so often, they get boring too." Another person said, "There's nothing for people like me." They went on to explain they had an interest in books, current affairs and different types of music that were not provided by the service. We raised this with the manager, who was aware that people's interests were diverse within the service. She told us that a number of attempts had been made to set up additional activities in another area within the service for people who did not like taking part in the main activities. Suggestions made included the development of a library, a scrabble club, a book club and regular news or current affairs discussions. However, those people had not wanted to use this room, preferring to stay in the main communal area instead despite voicing discontent with the activities that were provided in that area. Some people we spoke with were happy with the activities provided by the service. One person said, "I'm an Elvis fan and they have an Elvis impersonator." Another person said, "I like to go to [name of church] for lunch. Someone pushes me there. It's nearby."

Staff felt that people had enough activities to occupy their day. They said that the activities coordinator was good and tried their best to make sure that people had opportunities to enjoy individual interests, as well as socialise with others. They had seen the activities coordinator interact with people mainly cared for in their bedrooms to minimise the risk of isolation. This was confirmed by one person we spoke with who was cared

for in their room. They said, "The entertainment lady comes up to see me and is very jovial."

The provider had an up to date complaints policy and people and their relatives were aware of how to complain should the need arise. We looked at the complaints log and found that complaints had been responded to appropriately and in line with the provider's policy. The manager had developed a system to audit complaints to ensure that they were learned from and that improvements were made as a result.

Good

Is the service well-led?

Our findings

There was a registered manager in post.

At the inspection in June 2016, although the provider had a system for quality monitoring visits to be completed by the senior management team, these visits had not been taking place regularly. As a result the provider's oversight of the service was not effective and shortfalls in the quality of the service had not been identified or acted upon. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made. Regular provider visits were taking place and clear action plans were produced. At each visit, actions from the previous visits were reviewed to check that improvements had been made. This supported the service to continually improve.

The registered manager had developed a series of comprehensive audits to oversee the quality of each aspect of the service. These covered issues such as medicines, clinical records, care plans, infection control, and call bell response times. Each audit provided a detailed picture of that particular aspect of the service. For example, the call bell audit enabled the manager to identify the length of time each person waited when they called for assistance, the time of day the call was made, and the needs of the person. This enabled the manager to identify patterns and trends for call bell use which, along with a recognised dependency tool, informed rota planning and staffing numbers for particular times of day. We noted that there had been a significant improvement in call bell response times in recent months, following the introduction of this audit.

People had mixed views about the visibility and responsiveness of the registered manager, with some people feeling they did not have enough access to her. One person said, "[Manager] is not very engaged, not communicative." Another person said, "The Manager listens and says yes, but nothing happens." However other people said they found the registered manager approachable and responsive to any issues they raised. We discussed this mixed feedback with the manager who was concerned that some people felt this way and said she would look at ways to make herself more clearly available. On the day of the inspection we saw that people knew who the manager was, and they appeared comfortable in her presence and able to talk to her about issues. She appeared familiar with matters that people discussed with her. We saw that meetings had been held with people and relatives throughout the year to seek their views and to share information about the service.

The manager had been in post for just over one year, and in that time had worked hard to make considerable improvements to the service. This had required her to take up a different management style than previously experienced in the service in order to facilitate a change in the culture. As a result we found that a person centred culture was embedded within the service and this was built on the foundations of robust systems to support continuous improvement. This had necessitated a review of staff roles and required nurses and senior care staff to be more involved in the day to day management issues that arose, giving the manager the time to oversee the changes required. Staff spoke very highly of the manager and told us they found her approachable and responsive to their views. One member of staff said, "[Manager] is

always about and walking around the home. She's always there if residents want to chat to her." Another member of staff said, "We work well as a team and I get on with everyone. The manager is supportive to staff and really helpful."

Staff we spoke with had a person centred approach to their work and a good understanding of their role and responsibilities. They had confidence that they could speak with the manager about any concerns or ideas for improvement that they had and that the manager would listen and take action as appropriate.