Colville Care Limited

Beggars Roost Nursing 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

This inspection took place on 5 and 9 July 2018 and was unannounced.

Beggars Roost Nursing Home is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation and nursing or personal care for up to 28 people and there were 23 people living at the home at the time of the inspection. Beggars Roost Nursing Home is a detached property in a rural location. It is an older residential property which has been extended and adapted to be suitable as a residential care and nursing home. There was a passenger lift so people can access the first floor and corridors had sloping floors rather than steps for those with mobility needs. All bedrooms were single and nine had a en suite bathroom and seven had an en-suite toilet. There is a lounge and separate conservatory area which is used as dining room and for activities. The home had gardens and outdoor space which people used to sit in, to garden in, or, to have their meals during summer.

At our last inspection we rated the service Good. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

We made a requirement at the last inspection as people were not fully involved in planning their care and as care did not always reflect people's preferences. The provider sent us an action plan to say how this was being addressed. At this inspection we found improvements had been made. People were involved in decisions about their care which reflected their preferences and changing needs. The provider had met this regulation.

The provider ensured safe care was provided to people. Risks to people were assessed and measures taken to mitigate these. The premises and equipment were safely maintained. Sufficient numbers of care and nursing staff were deployed to meet people's needs. Checks were made to ensure staff were suitable to work in a care setting. Medicines were safely managed. The home was clean and hygienic with no offensive odours. Incidents or accidents were reviewed and action taken to reduce the likelihood of any reoccurrence.

The provider and management team ensured current guidance and legislation was followed regarding people's care and treatment. Staff were well trained and supervised. The staff felt supported and valued.

People's nutritional needs were assessed and people were supported to eat and drink. There was a choice of food. Health care needs were monitored and referrals made to other services to ensure there was a coordinated approach to people's care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the

service supported this practice.

People were treated with kindness, respect and compassion. Care was individualised and reflected people's preferences and changing needs. People's privacy and dignity were promoted.

People received personalised care which was responsive to their needs. The provider identified and met people's communication needs. A range of activities were provided which were based on people's choices and their needs. The provider had an effective complaints procedure and people and their relatives confirmed they were listened to and changes made when requested. The provider had links with hospice services regarding the provision of end of life care.

The service was well led and provided person centred care based on its values of treating people with dignity, promoting independence and rights to privacy and dignity. People and their relatives had opportunities to express their views about the service and were consulted about their care. A number of audits were carried out regarding the quality of the service.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service has improved to Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Beggars Roost 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 was 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 5 and 9 July 2018 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 service.

Before the inspection we checked information that we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We did not ask the provider to compete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with eight people who lived at the home and four relatives. We spoke with two care staff, a Registered General Nurse (RGN), a team leader, the chef, the deputy manager and two representatives of the provider.

We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI) which is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care plans and associated records for four people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents, records of

medicines administered to people and complaints. We looked at staff training records and staff supervision records.

We received feedback from a local NHS Clinical Commissioning Group who funded a number of placements at the service.

Good

Is the service safe?

Our findings

People and their relatives said the staff provided safe care. For example, one relative said, "I'm never worried about the safety of my relative here because I know she's safe and treated very well." People said they felt safe at the home. For example, one person told us, "I feel very safe here and I have no worries."

Staff had a good awareness of the principles for protecting people and reporting any concerns to their line manager, the provider or to outside agencies such as the local authority.

Risks to people were assessed and safely managed. People and relatives said care was provided by staff in a safe way. Where risks were identified these were assessed and corresponding care plans recorded so staff had guidance on how to mitigate risks. These included risks assessments regarding mobility, for supporting people to move safely and for falls. Risks of pressure areas developing on people's skin due to immobility were assessed and there was care plan guidance recorded of how those risks were reduced. The care plans were recorded on an electronic system which alerted staff to aspects of people's lives and care where there was a risk.

People and their relatives said there were enough staff to meet their needs. For example, one person said, "There are a lot of staff here and I see the same people regularly." Another person said, "They are always staff walking up and down the corridors so I know that there is someone available if I need them." People and their relatives said staff responded promptly when they asked for assistance using the call points. A relative, for instance told us, "The staff seem to respond quite quickly to the call bell." At the time of the inspection there were 23 people living at the home. The provider assessed the following staffing levels as needed to meet people's needs: one Registered General Nurse (RGN), and five care staff from 8am to 2pm and one RGN and three care staff from 2pm to 8pm. Night time staffing consisted of one RGN and two care staff. These staff hours were recorded on the staff duty roster. There were also ancillary staff for preparing meals, maintenance staff, an administrator and staff for activities. Staff told us there were enough staff to meet people's needs.

Medicines were safely managed. Records and medicines stocks showed medicines were administered to people as prescribed. Medicines were safely stored and the temperature of the medicines storage room and fridge monitored.

We looked at the staff recruitment procedures. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. Checks were made to confirm nursing staff were registered with the Nursing and Midwifery Council (NMC).

Checks were made by suitably qualified persons of equipment such as the fire safety equipment, fire alarms, electrical appliances, electrical wiring, hoists and passenger lift. Hot water was controlled by specialist mixer valves so people were not at risk of being scalded by hot water and the water temperature was checked. There were procedures for the safe storage and use of oxygen where people needed this. First floor windows

had restrictors so people could not fall or jump out. Each person had a personal evacuation plan so staff knew how to support people to evacuate the premises in the event of an emergency. The staff were trained in fire safety and the alarms and emergency lighting were tested as required. There were contingency plans in place in the event of a fire or when there was a need to evacuate the premises. The temperature of hot water was checked to ensure it was hot enough to combat risks of Legionella. The provider used a contractor to check the water system for Legionella.

Procedures for the prevention and control of infection were comprehensive. There were policies and procedures regarding the prevention of infection based on guidance from the Infection Control Society. Checks and audits on infection control were carried out to a good standard. Hand sanitisers were available for staff and visitors to use. Staff were observed using protective clothing to prevent the spread of infection. The risks of infection and its prevention was assessed for each person. The home was found to be clean, hygienic and free from any offensive odours.

Records and discussion with staff showed any incidents, accidents or near misses were looked into and an action plan devised to prevent any reoccurrence where this was needed.

Good

Is the service effective?

Our findings

People and their relatives said the staff were skilled at meeting their care needs. For example, one person said, "The staff support me with my needs. I am slow with my speech and I find that the staff give me the time I need to explain things." A relative told us, "The care that the staff provide is exceptional." Another relative said, "Staff are great. Any issues are resolved. The care is just brilliant."

The RGNs and care staff had strong links with organisations who provided advice and updates on the provision of effective care, such as a from local hospice as well as updates from nursing publications. The deputy manager who was an RGN had extensive knowledge of each person's needs and current procedures regarding care provision as well as the training needs of staff. Policies and procedures were displayed for staff regarding guidance from the Royal College of Nursing (RCN), the management of pressure areas on people's skin, supporting people who had swallowing difficulties and the care of people with Parkinson's disease.

Staff told us training was provided in the provision of care such as using a percutaneous endoscopic gastronomy (PEG) to feed people and supporting people with hydration at the end of their lives. A percutaneous endoscopic gastrostomy (PEG) tube is passed into a person's stomach by a medical procedure and is most commonly used to provide a means of feeding or receiving medicines when oral intake is not possible.
The staff said the training was good and that their training needs were reviewed. For example, one staff member said, "Anything you are interested in they will put you on a course to update your knowledge." Staff confirmed they received supervision and appraisals of their work and felt supported. There were records of staff supervision. The deputy manager told us there was system of peer supervision for the RGNs.

Newly appointed staff were supported with an induction which involved a period of 'shadowing' other staff. Records showed staff induction was comprehensive. A training spreadsheet was maintained so the provider could monitor staff had attended courses considered mandatory to their role. Twelve of the 15 care staff had a National Vocational Qualification (NVQ) or Diploma in Health and Social Care at levels 2 or 3. A further three staff were completing this or were enrolled on the Care Certificate. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

People were supported with food and drink. Nutritional needs were assessed using a recognised format called a malnutrition universal screening tool (MUST). Referrals were made to dietician services where this was needed. Specialist diets were catered for such as for people with diabetes or soft diets or where people needed their food fortified to increase its calorific value. People said they liked the food and confirmed there was choice. For example, one person said, "Eating the food is the highlight of my day." A relative said how well staff supported someone who was fed via a percutaneous endoscopic gastronomy (PEG).

The provider and staff worked well with other organisations to provide a coordinated approach to care. Records showed there was joint working with community psychiatric services, onward referrals were made

for specialist services and medical and nursing assessments. Health care needs were monitored and recorded to a good standard. People said they were supported to access health care via their GP when needed.

The premises were well maintained and adapted for the people who lived there. The home was bright and airy. There were areas where people could sit together either in the lounge or dining areas. There was also an area where people could take part in games and crafts. There was enough space for people who had disabilities to be able to move around. People's bedrooms were personalised with their own belongings.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Care records showed people were consulted about their care and had signed their care plans. Where people did not have capacity to consent to their care and treatment this was assessed using a recognised MCA toolkit. These were recorded to a good standard and were specific to aspects of care where it was believed people may not have capacity to consent to their care. Where decisions were made on behalf of people there was a record of a best interests decision which involved relevant professionals and the person's relative.

Good

Is the service caring?

Our findings

At the last inspection we found people were not always involved in the planning of their care and that people's preferences and choices were not always catered for as the service was often governed by routines. We made a requirement for this to be addressed. The provider submitted an action plan of the steps they would take to meet this requirement. At this inspection we asked people if they were involved in their care and if the service they received met their preferences. People and their relatives said the service provided was flexible to meet people's needs and preferences. For example, one person said, "I have set meals, I always eat the same foods for lunch and the chef knows this. He is very good at making the meals just how I like it," and, "I am given plenty of freedom and the staff always give me the choice to make my own decisions". Another person said, "The staff never force me do anything I don't want to. They give me the freedom and make me feel at home". A relative said, "I have seen that the staff always try and encourage the residents make their own decisions. Nothing is forced upon anyone".

Care records included details about people's preferences and a person-centred care planning document had been completed for each person. There was also a care record for each person called, 'This Is Me,' which had details of preferences and routines as well as a social history. The deputy manager was clear about people's rights to make their own decisions even if this involved an element of risk. Care records showed people were consulted and involved in decisions about their care. A relative said staff listened to what people said, "They listen to him. They sort things out for him. They are very caring." We judged the requirement made at the last inspection is now met.

People were treated with kindness, respect and compassion. Comments made by people included the following, "The staff are very polite and kind towards me." Relatives also confirmed people were treated with compassion and respect; for example, one relative said, "The staff here are brilliant, they show respect and I know that I can go home knowing that my relative will be looked after very well." Another relative said, "The care that the staff provide is exceptional. They show a lot of affection and compassion towards my relative." We observed staff treated people with kindness and knew people well. Interactions between staff and people were friendly and warm with much laughter and humour. A relative said staff provided good companionship and that staff interaction helped their relative to be more cheerful and outgoing.

Staff demonstrated they were committed to the promotion of people's well-being and treated people as they would like to be treated or a family member would be treated. For example, one member of staff said, "Care is based on what the person wants. We ask what they want. They are able to choose." Another staff member said, "I treat people with empathy and compassion. It's important to listen to people and to take your time. We pass this approach on to new staff." Staff were trained in dignity, equality and diversity and said they were aware of the need to treat people equally irrespective of age, disability, sex or race.

People's privacy was promoted. We observed staff knocked on people's bedroom doors before entering. Staff said their training include the importance of privacy to people. The deputy manager said people were able to have a lock for privacy and security on their bedroom door if they wished and that people also had a choice if they preferred care from either male or female staff. People said their privacy was respected. For

example, one person said, "I am given lots of privacy and there are both male and female staff available."

Good

Is the service responsive?

Our findings

People received a responsive service which reflected their changing needs and individual preferences. People confirmed they were consulted and involved in decisions about their care. For example, one person told us, "I have a care plan and the staff know about my needs. If I have any problems, I speak to the matron (registered manager) about it." Another person said, "I have been here for many years now and the staff know me very well. We will sit down and talk and if there is anything I need or want changed I will tell the staff and make plans for changes".

Care records showed people's needs were assessed before they were admitted to the home. The assessments of people's care needs were comprehensive and showed people and their relatives were consulted. Care plans were individualised and person centred. People's wishes and preferences were recorded and daily records showed when these were updated to reflect people's changes in need and preferences. Regular reviews of people's care took place and was recorded.

We looked at how the service was meeting the requirements of the Accessible Information Standard (AIS) as required by the Health and Social Care Act 2012. This requires service providers to ensure those people with disability, impairment and/or sensory loss have information provided in an accessible format and are supported with communication. People's communication needs were assessed and people had a communication care plan which were of a good standard. People and their relatives said staff were good at communicating with people. Specialist equipment was used to assist people to communicate. This included iPads which were used by staff with people and a touch pad system whereby the person could control their television and ask for assistance from their bed. The provider was in the process of developing a policy regarding the AIS.

The provider employed two activities coordinators who met with people to decide the type of activities they would like. There was a weekly activities programme which ranged from group events such as quizzes, singing, music and movement, cooking and gardening. Areas of the garden had been adapted to make it easier for people to be involved in gardening. Outings to local attractions took place such as Arundel wetlands and a historic estate in the South Downs. People and their relatives confirmed they were satisfied with the activities. For example, one person said, "Some of the activities we do are, quizzes, chair exercises, arts and crafts (card making) and Thursday Holy Communion." A relative told us, "There is a weekly activity sheet printed and everyone has their own copy. I think there plenty of activities available." Records and discussions with relatives showed staff supported people with one to one activities in their room if they were unable to join in with the group events.

The provider confirmed people were supplied with a copy of the complaints procedure in the 'Client Guide.' People and their relatives confirmed the provider was open to suggestions or comments which were responded to. For example, one person said, "I wasn't happy with the salads for lunch. They seemed very plain. The chef changed the menu and added tomatoes in mine. The staff will always listen and try to help where they can". A relative also confirmed the registered manger responded to any issues, "If there are any problems, I feel comfortable talking to the matron and I know she will respond immediately". There was also

a system where people and relatives could raise any issues anonymously. There was one complaint in the 12 months prior to the inspection; records showed this was looked into and actions taken where needed.

At the time of the inspection there no people in receipt of end of life care. The provider was linked to a local hospice who had validated the service as accredited in the Six Steps to Success in end of life care. This is a recognised approach to providing a responsive care to people at the end of their life. The provider was also registered with a forum run by the NHS called ECHO: end of life care for coastal West Sussex in order that staff were supported with guidance on best practice in this area and for coordinating end of life care. Staff said they were trained in procedures for supporting people at the end of their lives. One staff member said two people who had been in receipt of end of life care were still well one year later, which reflected the good standard of care given.

Good

Is the service well-led?

Our findings

The service was well led with an open culture which facilitated good communication with people and their relatives. People views were sought regarding their care and for how services were provided, such as activities. People and their relatives confirmed there was a culture where they were consulted and involved in decisions about the home. For example, one person said, "We usually talk over lunch and dinner when all the residents are together. I know that if there was anything I wanted to change the staff would do it". A relative also described how they were involved in the service, "There is family and friend's committee which we can join. The staff are involved in this. There are regular meetings where we can all get to together and have an update on and share our thoughts".

The provider had a statement on its philosophy of care which included a commitment to people's right of privacy and dignity, their views being acknowledged and the rights to privacy and dignity. These values were reflected in how people received a 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. Staff said they felt supported and valued by the management team who they felt comfortable raising any issues with. There was system of management structure and delegation of a deputy manager, three RGNs who took lead for decision making on shifts being worked plus three team leaders.

Surveys were used to gain the views of people and relatives about the standard of care. The last survey showed 92% of people or their relatives considered the standard of service as good or outstanding. People and visitors were also encouraged to make comments and suggestions via the provision of forms in the hallway.

Audits and checks were carried out regarding infection control, the safe management of medicines, staff training and individual care and health needs. There were actions plans where it was noted changes were needed. A local NHS Clinical Commissioning Group (CCG) who monitored the care of people they funded at the home reported the standard of care as being good.

Records were well maintained and were secure and confidential. The provider was aware of the recent legislation regarding access and retention of personal data on staff and people called General Data Protection Regulation (GDPR), which was effective from 25 May 2018. Specific policies and procedures were being devised to ensure compliance with this legislation.

The provider and staff worked in partnership with other agencies and safeguarding team to ensure a coordinated approach to care. This included working with a local hospice, dietician services and local community psychiatric services.