Unannounced Care Inspection Report
29 May 2019

The Beeches Professional & Therapeutic Services

Type of Service: Nursing Home
Address: 9-11 Lurgan Road, Aghalee, BT67 0DD
Tel No: 028 9265 2233
Inspector: Dermot Walsh

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which provides care for up to 41 patients.

3.0 Service details

Organisation/Registered Provider: The Beeches Professional & Therapeutic Services Ltd **Responsible Individual:** James Brian Wilson	**Registered Manager and date registered:** Carmel Nelson 9 March 2007
Person in charge at the time of inspection: Carmel Nelson	**Number of registered places:** 41 Associated PD under and over 65.
Categories of care: Nursing Home (NH) LD – Learning disability. LD(E) – Learning disability – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 36

4.0 Inspection summary

An unannounced inspection took place on 29 May 2019 from 09.15 to 17.45.

This inspection was undertaken by the care inspector.

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to staffing arrangements, recruitment procedures, staff training and development, adult safeguarding, care planning and governance of incident and complaint management. Further good practice was found in relation to the delivery of compassionate care and maintaining good working relationships.

Areas requiring improvement were identified in relation to the provision of signage in the home, recording of food and fluid intake and with the auditing of care plans.

Patients described living in the home in positive terms. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with staff.

Comments received from patients, people who visit them and professionals and staff during and after the inspection, are included in the main body of this report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	3

Details of the Quality Improvement Plan (QIP) were discussed with Carmel Nelson, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent inspection dated 14 August 2018

The most recent inspection of the home was an unannounced care inspection. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings; registration information; and any other written or verbal information received, for example, serious adverse incidents.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home.
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home.
- observe practice and daily life.
- review documents to confirm that appropriate records are kept.

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire. A poster indicating that an inspection was taking place was displayed at the entrance to the home and invited visitors to speak with the inspector.

The following records were examined during the inspection:

- duty rota for all staff week commencing 20 May 2019
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- one staff recruitment file

- three patient care records
- a sample of governance audits/records
- complaints record
- compliments received
- RQIA registration certificate.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as either met, partially met, or not met.

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of outstanding areas for improvement from previous inspection

Areas for improvement identified at the previous care inspection have been reviewed. All three areas for improvement have been met.

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager confirmed that the number of staff and the skill mix of staff on duty at any given time was determined through regular monitoring of patient dependency levels in the home. A review of the duty rota for week commencing 20 May 2019 confirmed that the planned staffing level and skill mix was adhered too. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the care staff. Patients' needs and requests for assistance were observed to have been met in a timely and caring manner. Patients and their visitors consulted spoke positively in relation to the care provision in the home. Staff confirmed that they were satisfied that the staffing arrangements were sufficient to meet patients' needs at all times.

A review of one staff's recruitment records confirmed that the appropriate pre-employment checks had been completed prior to the staff member commencing in post. References had been obtained and records indicated that AccessNI checks had been conducted. Checks were made on registered nurses to ensure that they were registered with the Nursing and Midwifery Council (NMC). Similar checks were made on care workers to ensure that they were on the Northern Ireland Social Care Council (NISCC) register and that no restrictions to their employment had been identified. New care staff were required to join the NISCC register as soon as possible following commencement of employment. The registered manager evidenced regular checks made on all staff following employment in the home to ensure that they maintained their registration with NMC and NISCC as appropriate.

A record of any training that staff had completed was maintained in the home. Staff were positive in relation to the training provision. Discussion with staff and a review of records evidenced that training was conducted both electronically and face to face. There was evidence of recent adult safeguarding training and fire safety training having been conducted. Fire safety training had also been conducted overnight to facilitate night duty staff. Staff confirmed that the home's management encouraged staff to suggest additional training which would further enhance their roles within the home.

An adult safeguarding champion had been identified to manage any potential safeguarding incidents. Discussion with the registered manager confirmed that they were aware of the regional safeguarding policy and procedures. Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns.

A review of three patients' care records evidenced that appropriate individualised risk assessments were completed on each patient at the time of their admission. Risk assessments had been reviewed regularly and care plans had been developed which were reflective of the risk assessments. Care plans had also been reviewed and updated regularly.

Falls in the home were monitored on a monthly basis to detect if there were any patterns or trends in the falls as a way of proactively preventing future falls from occurring. A review of accident records associated with the falls evidenced that the appropriate actions had been taken following the falls and the appropriate persons had been notified of the accidents.

We reviewed the home's environment undertaking observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was clean and fresh smelling. There were no malodours detected in any part of the home. Fire exits and corridors were observed to be clear of clutter and obstruction. Stairwells were also observed to be clear. Records of fire drills in the home were maintained and included the participants' names and a report of the response to the drill. Compliance with best practice on infection prevention and control had been well maintained. Shower chairs had been maintained clean following use. An area for improvement in this regard has now been met. Personal protective equipment (PPE) was available and staff were observed to use PPE appropriately and to promote hand hygiene. Isolated infection control issues identified were managed during the inspection. There was evidence of ongoing refurbishment in the home. A painting programme was in progress and the flooring of the communal corridor on the first floor was in the process of being replaced. The registered manager confirmed that a number of the patients' bedrooms had been identified for refurbishment.

During the review of the environment we identified that navigating around the home was difficult as signage was not consistently evident to signify the use of rooms and promote path finding. An area for improvement was made in this regard.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing arrangements, recruitment procedures, staff training and development and adult safeguarding.

Areas for improvement

An area for improvement was identified in relation to the provision of signage in the home to promote path finding.

	Regulations	Standards
Total number of areas for improvement	0	1

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome.

There was evidence within three patients' care records reviewed that appropriate risk assessments were completed on admission and reviewed on a regular basis. Risk assessments had been completed on falls management, nutrition, pressure management and restraint. Care plans had been developed which were reflective of the risk assessments. The care plans had also been reviewed regularly or as the patients' needs changed. An area for improvement in this regard has now been met. Registered nursing staff confirmed that there were no wounds in the home requiring dressing.

Dietary requirements, such as the need for a gluten free or diabetic diet, were communicated through staff handovers. Information also included the consistency of patients' food and fluids. Training in using new International Dysphagia Diet Standardisation Initiative (IDDSI) indicators to ensure that patients were safely given the correct foods and fluids was implemented. Patients had been weighed regularly and a nutritional screening tool known as Malnutrition Universal Screening Tool (MUST) was implemented to determine the risk of weight loss or weight gain. Where a risk was identified there was evidence within patients' care records that advice was sought from an appropriate health professional such as a dietician or a speech and language therapist. Patient care records also evidenced that advice received from health professionals were incorporated within the patients' care plans. Patients and staff confirmed that they had 24 hour access to food and fluids. Patients and staff commented positively on the food provision in the home. An area for improvement was identified in relation to the recording of food and fluid intake. Food and fluid intake records had been maintained, however, improvements in relation to the detail of recording were identified with the registered manager.

The serving of lunch was observed from 12.15 in the dining room on the ground floor. Patients who did not wish to eat in the dining room were facilitated with their meal in their preferred dining area where appropriate. Food was served from heated trolleys which were placed away from where the patients were eating. Food was only served when patients were ready to eat or be assisted with their meals. The food served appeared nutritious and appetising. Staff were observed to dine with patients which ensured close supervision where required and promoted social interaction. Staff encouraged patients with their meals and patients were observed to be assisted in an unhurried manner. Staff wore the appropriate aprons when serving or assisting with meals and patients wore clothing protectors where required. A range of drinks were offered to the patients. Staff confirmed that alternatives were made available where patients did not prefer either choice of meal on the menu. Patients appeared to enjoy the mealtime experience.

Patients' risk of pressure related skin damage was assessed on their admission and reviewed. Improvements in relation to the frequency of these assessments on identified patients were discussed with the registered manager. We reviewed one patient's care records where the patient was receiving treatment for two separate wounds. Each of the wounds had a separate care plan and these care plans reflected the recommendations of a tissue viability nurse. There was good evidence that the wounds were closely monitored to ensure healing and that the wounds were not deteriorating.

When a restrictive practice, such as the use of bedrails had been implemented, there was evidence within the patient's care records of an initial assessment completed to ensure safe use. This assessment was reviewed regularly. The continued use of restraint was monitored at the evaluation of the patients' care plans.

All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Staff confirmed that the shift handover provided them with all necessary information to provide care to patients. Staff also confirmed that a communication book was maintained in the home identifying any significant changes and that staff would refer to the communication book regularly or when returning from a period of annual leave. Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/management.

Each staff member was aware of their roles and responsibilities within the team. Comments from staff included teamwork was: "Really good" and "Everyone works really well together". Staff also confirmed that if they had any concerns, they could raise these with the registered manager or the nurse in charge. Staff commented that the home's management were, "Very approachable" and "Would always listen to any concerns raised."

Areas of good practice

There were examples of good practice found throughout the inspection in relation to care planning, communication and teamwork.

Areas for improvement

An area for improvement was identified in relation to supplementary record keeping in respect of food and fluid intake.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff were aware of individual patients' wishes, likes and dislikes. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were given choice, privacy, dignity and respect. Staff were also aware of patient confidentiality regarding the handling and use of patient information.

The environment had been adapted to promote positive outcomes for the patients. Bedrooms were maintained clean and tidy and personalised with possessions that were meaningful to the patient and reflected their life experiences.

A sensory room in the home was utilised well. Patients were observed relaxing in this room with specialised lighting creating a relaxing environment and an audio book playing in the background. One patient was receiving a hand massage while listening to the audio book. Reflexology was delivered in another identified room in the home. A weekly activity programme was displayed outside the sensory room where patients and their visitors could see planned activities. Discussion with the activity co-ordinator confirmed that activities were planned outside of mealtimes and times where personal care would be delivered. The activities incorporated group work and one to one engagement with patients as well as outings and attendance at social events. Activities included arts and crafts, music making workshops, armchair aerobics, reminiscence work and movie sessions. An activity report was generated quarterly monitoring the effectiveness of the activities and identifying future plans.

Cards and letters of compliment and thanks were available for review in the home. One of the comments recorded included:

- "After visiting many nursing homes over the years, I was so impressed I felt I had to write how clean, bright and welcoming the Beeches is! Definitely a home from home with the personal touch."

Consultation with 10 patients individually, and with others in smaller groups, confirmed that living in The Beeches Professional and Therapeutic Services was a positive experience. Patient questionnaires were left for completion. One was returned within the timeframe. The respondent indicated that they were very satisfied that the home provided safe, effective, compassionate care and that the home was well led.

Patient comments:

"I love it here."
"It is alright here."
"I am loving it here."

Three patient representatives were consulted during the inspection. Patient representatives' questionnaires were left for completion. Six were returned. The respondents indicated that they were very satisfied with care provision in the home and that the home was well led. Some patient representatives' comments were as follows:

"I am so happy with the care in the home. It is wonderful. The home is always clean and the staff are so attentive."
"We are very happy with the care here. … is very well settled here. Staff always keep us up to date. Have no complaints at all."
"All staff are very good."
"As usual, the Beeches is managed to a very high standard."
"The staff are very caring and friendly. There is a wonderful atmosphere in the home."
"Every member of staff on hand at all times and no problem to big or to small. They treat all with respect."

Staff were asked to complete an online survey; we had no responses within the timescale specified. Comments from 11 staff consulted during the inspection included:
"It is home from home here."
"I absolutely love it here."
"They (management) are really good support wise."
"The patients are treated amazingly here."
"The work is enjoyable. We have great fun."
"It has been great getting to know all the patients."
"Great teamwork here."
"Couldn't get any better."

Two questionnaires were returned which did not indicate if they were from patients or relatives. Both respondents indicated that they were very satisfied that the home delivered safe, effective and compassionate care and that the home was well led.

Any comments from patients, patient representatives and staff in returned questionnaires or online responses received after the return date will be shared with the registered manager for their information and action, as required.

A visiting professional was consulted during the inspection. The visiting professional was complimentary in respect of good communication with staff; staffs' knowledge of their patients; reporting of incidents and with staffs' interactions with patients.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home in maintaining the dignity and privacy of patients and valuing patients and their representatives.

Areas for improvement

No areas for improvement were identified during the inspection in the compassionate domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. This certificate identifies the management arrangements for the home and the maximum number of patients allowed to be accommodated in the home. Since the last care inspection, the management arrangements in the home had not changed. Discussion with the registered manager and staff, and observations confirmed that the home was operating within its registered categories of care.

Staff confirmed that the registered manager was 'always visible in the home'. Staff also confirmed that the registered manager was always available to provide guidance or advice during and out of normal office hours.

The registered manager confirmed that they had not received any recent complaints in the home relating to patients' care or in relation to the provision of any service in the home. A system was in place to record any complaints received including all actions taken in response to the complaint. Patients and their visitors consulted during the inspection confirmed that they would have no issues in raising any identified concern with the home's staff or management.

Monthly monitoring visits were conducted by the responsible individual (RI) for the home. The RI would review the care provision and service provision of the home and generate a report of the visit. Any areas identified for improvement would be documented as discussed with the registered manager or nurse in charge and identified within an action plan included in the report. There was evidence within the reports that the previous month's action plan was reviewed as part of the visit to ensure that actions identified had been completed. Reports were available for review by patients and their visitors, staff, Trust staff and other healthcare professionals.

Discussion with the registered manager and review of auditing records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, care records, wound care, restrictive practices and infection prevention and control practices. We reviewed the care record audits during the inspection. Each patient's care records were audited annually. Shortfalls had been identified within the auditing records. However, there was not sufficient evidence that an action plan had been developed and reviewed to ensure rectification of the identified shortfalls. This was discussed with the registered manager and identified as an area for improvement.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements on the management of incidents and complaints and with maintaining good working relationships.

Areas for improvement

An area for improvement was identified in relation to the auditing of patient care records.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Carmel Nelson, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales. Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 43 Criteria (1) **Stated:** First time **To be completed by:** 31 July 2019	The registered person shall consider the use of signage in the home to promote way finding. Ref: 6.3
	Response by registered person detailing the actions taken: A plan has been discussed and agreed and use of signage will be implemented. This will commence with signage on store rooms and bathrooms/ toilets.
Area for improvement 2 **Ref**: Standard 4 Criteria (9) **Stated:** First time **To be completed by:** 23 June 2019	The registered person shall ensure that supplementary record keeping in relation to food and fluid intake is enhanced to contain further details improving the accuracy of the recording. Ref: 6.4
	Response by registered person detailing the actions taken: The diet recording sheet has been improved and the staff team are aware of the additonal information required for the individuals in the at risk category.
Area for improvement 3 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 31 July 2019	The registered person shall ensure that action plans are developed when shortfalls are identified within patient care record audits and that these action plans are reviewed to ensure completion. Ref: 6.6
	Response by registered person detailing the actions taken: When care plan audits have been completed, the action plan will be discussed with the named nurse and a date set for review of this plan to ensure completion of same.

Please ensure this document is completed in full and returned via Web Portal

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