Inspection Report

28 January and 3 February 2022

The Beeches Professional & Therapeutic Services

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

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: The Beeches Professional & Therapeutic Services Ltd **Responsible Individual:** Mr James Brian Wilson	**Registered Manager:** Mrs Carmel Nelson **Date registered:** 9 March 2007
Person in charge at the time of inspection: Mrs 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:** 35
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 41 patients. Patients' bedrooms are located over two floors in the home and patients have access to communal lounges and a dining room.	

2.0 Inspection summary

An unannounced inspection took place on 28 January 2022 from 9.15am to 4.30pm by a care inspector and continued on 3 February 2022 from 10.45am to 4.15pm by a finance 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.

Patients were well presented in their appearance and spoke positively when describing their experiences on living in the home. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients and staff are included in the main body of this report.

Staff promoted the dignity and well-being of patients and were knowledgeable and well trained to deliver safe and effective care. There was a good working relationship between staff and management.

Three areas for improvement were identified from this inspection in relation to pressure management risk assessments, the menu and the management of records for patients' personal property.

RQIA was assured that the delivery of care and service provided in The Beeches Professional and Therapeutic Services was safe, effective and compassionate and that the home was well led.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice and to address any deficits identified during our inspections.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with the manager at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we consulted with 10 patients and eight staff. Patients spoke positively on the care that they received and with their interactions with staff. Patients also complimented the food and activity provision in the home. Staff were confident that they worked well together and enjoyed working in the home and interacting with the patients.

There were seven questionnaire responses; four from relatives and three from patients. All respondents indicated that they were very satisfied the care in the home was safe, effective and compassionate and that the home was well led. There was no feedback from the staff online survey.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to The Beeches Professional & Therapeutic Services was undertaken on 11 March 2021 by a care inspector; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Staffing Arrangements

Staff had been recruited safely ensuring that all pre-employment checks had been completed and verified prior to the staff member commencing in post.

All staff were provided with a comprehensive induction programme to prepare them for working with the patients. Checks were made to ensure that nursing staff maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

There were systems in place to ensure staff were trained and supported to do their job. For example, staff received regular training in a range of topics such as infection prevention and control (IPC), patient moving and handling and fire safety. A system was in place to ensure that staff completed their training. Staff told us that they could request additional training relevant to their role in the home. Upcoming training was identified on a staff noticeboard in the home.

The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met. Staff agreed that patients' needs were met with the number and skill mix of staff on duty. Staff said there was good teamwork in the home and that they supported one another throughout the working day. One staff told us, "I am very proud to be a nurse here," and another commented, "I am always happy and content coming to work." Staff were observed working well and communicating well together throughout the inspection.

The staff duty rota accurately reflected all of the staff working in the home on a daily basis and the designation in which they worked. The duty rota identified the nurse in charge of the home when the manager was not on duty. The nurse in charge was also identified on a notice at the entrance to the home.

Patients spoke highly on the care that they received and confirmed that staff attended to them when they needed them and that they would have no issues on raising any concerns that they may have to staff. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner. It was clear through these interactions that the staff and patients knew one another well and were comfortable in each other's company.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of patients' needs, their daily routine, wishes and preferences. A diary was maintained to ensure important daily activities were not missed such as blood tests or appointments. Staff confirmed the importance of keeping one another up to date with any changing needs in patients' care throughout the day.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering; discussing patients' care in a confidential manner and by offering personal care to patients discreetly. This was good practice. Staff were observed to be prompt in recognising patients' needs and any early signs of distress, especially in those patients who had difficulty in making their wishes known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to their needs.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals. Patients' care records were held confidentially.

Patients who were less able to mobilise required special attention to their skin care. These patients were assisted by staff to change their position regularly. A record of repositioning had been maintained and included evidence of skin checks on repositioning. We discussed further methods of enhancing the recording of repositioning.

Where a patient had a wound, a detailed wound care plan was in place to direct the care of the wound. Wound evaluation charts were completed at the time of wound dressing to monitor the progress of the care delivery.

Three patients' pressure management risk assessments were reviewed. Risk assessments had been completed on admission but had not reviewed frequently thereafter. For example, one of the patient's pressure management risk assessments had only been recorded on four occasions throughout 2021. Another had been recorded last during April 2021. This was discussed with the manager and identified as an area for improvement.

Where a patient was at risk of falling, a dedicated falls care plan was in place to direct staff in how to manage this area of care. Accidents in the home were monitored weekly and a monthly qualitative audit was completed to enable the manager to identify if any patterns were emerging which in turn could assist the manager in taking actions to prevent further falls from occurring. Accident records reviewed confirmed that the correct actions had been taken following the fall and the correct persons had been notified.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this could include simple encouragement through to full assistance from staff. Staff assisted patients throughout the day with food and fluids in an unhurried manner. Records of patients' intake and outputs were recorded where this was required. Nutritional risk assessments were carried out monthly to monitor for weight loss and weight gain using the Malnutrition Universal Screening Tool (MUST). The manager confirmed that all patients received a remote dietetic review every two months.

However, the menu displayed only offered one meal option and whilst it was evident that patients were being given a choice of different meals; an area for improvement was made to ensure that there was a choice of meal on the menu. Meal choice should also be available on the menu for those patients who require their meals to be modified. Patients were complimentary in regard to the food provision in the home and the food served appeared appetising and nutritious.

Patients' individual likes and preferences were reflected throughout the records. Daily records were kept of how each patient spent their day and the care and support provided by staff.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, storage spaces and communal areas such as lounges and bathrooms. The home was warm, clean and comfortable. There were no malodours detected in the home.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear. Fire extinguishers were easily accessible.

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were well decorated and suitably furnished. Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices.

Systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. For example, the home participated in the regional testing arrangements for patients and staff. In addition, staff performed Lateral Flow Tests (LFTs) prior to coming on duty. Relatives were also encouraged to perform LFTs prior to coming to visit. Environmental infection prevention and control audits had been conducted monthly.

All visitors to the home had a temperature check and symptom checks when they arrived at the home. They were also required to wear personal protective equipment (PPE). Visits were by appointment only.

Review of records, observation of practice and discussion with staff confirmed that effective training on IPC measures and the use of PPE had been provided. Signage promoting effective hand hygiene and safe use of PPE was displayed throughout the home. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV. Patients confirmed that they could remain in their bedroom or go to a communal room when they requested.

The provision of activities formed a large part of patients' lives in the home. Patients were observed in the activities room making Chinese dragons.

Patients were observed in the sensory room relaxing. Patients were also observed in their bedrooms and lounges enjoying several activities with staff. Two staff were employed to oversee the activity provision in the home and individual patient records of activity involvement were maintained daily. Activities in the home took into account group activity and one to one activity for those who could not, or did not wish to, be involved in the group activity. Activities included arts and crafts, literacy and numeracy skills, leisure games, relaxation, aerobics, gardening, nature trails and outings to nearby national parks taking social distancing into consideration. An enclosed garden area to the rear of the home was well maintained where patients could safely enjoy fresh air on the seating areas provided.

Visiting arrangements were in place in line with Department of Health guidelines with positive benefits to the physical and mental wellbeing of patients. Care partner arrangements had been offered, though, there had been no interested parties in taking these forward.

There were regular patient meetings conducted which provided an opportunity for patients to comment on aspects of the running of the home. Minutes of these meetings had been recorded and captured discussions had and decisions made on topics such as activity ideas, Covid-19 updates, infection control, what to do if you have any concerns, visiting arrangements, outings and any upcoming events.

5.2.5 Management and Governance Arrangements

Since the last inspection there has been no changes in the management arrangements. Mrs Carmel Nelson has been the registered manager of the home since 9 March 2007. Discussion the manager and staff confirmed that there were good working relationships between staff and management. Staff confirmed that the management team were approachable and would listen to them when they brought any concerns to their attention. Staff described the manager as ‘irreplaceable,’ and, ‘always available to provide guidance and support.

Staff were aware of who the person in charge of the home was in the manager’s absence. Staff told us that they were aware of their own role in the home and how to raise any concerns or worries about patients, care practices or the environment. Staff were aware of who to report their concerns to and who to escalate their concern to if they felt that this was required.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. Areas audited included patients’ care records, infection control and staff training. The manager had a system in place to monitor accidents and incidents that happened in the home.

It was noted that patients and their relatives were provided with written information on how to raise a concern or complaint about care or any service they received in the home. A complaints file was maintained. We discussed the importance of recording any areas of dissatisfaction expressed as a complaint and discussed further ways of enhancing the recording of complaints. Cards and compliments were kept on file and shared with staff.

Due to a Covid-19 outbreak in the home, the most recent monthly monitoring visits on behalf of the provider, to internally monitor the running of the home, had been conducted remotely. The reports of these visits were completed; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. Completed reports were available for review by patients, their representatives, the Trust and RQIA.

5.2.6 Findings from finance inspection

A safe place was provided within the home for the retention of patients' monies and valuables. At the time of the inspection there were satisfactory controls around the physical location of the safe place and the members of staff with access to it. Records of monies and valuables held at the home on behalf of patients were up to date at the time of the inspection.

A bank account was in place to retain patients' monies. A sample of statements from the bank account was reviewed, the account only contained patients' monies and was not used for the running of the care home. A sample of withdrawals identified from the bank statements was reviewed; the amounts withdrawn reflected the amounts recorded as lodged at the care home on behalf of patients. Comfort fund monies were also held on behalf of patients, these are monies donated to the home for the benefit of all patients.

A review of a sample of transactions from the comfort fund confirmed that records were up to date and that purchases from the fund were for the benefit of all patients.

A sample of records evidenced that reconciliations (checks) of monies held on behalf of patients were undertaken on a weekly basis. Records also showed that valuables held on behalf of patients were reconciled monthly. The records of the reconciliations were signed by two members of staff.

Discussion with staff confirmed that although patients' comfort fund monies were checked regularly, there were no records to confirm that the checks had taken place. The manager was advised to ensure that the checks on comfort fund monies were recorded as part of the audit process. This procedure will be reviewed at the next RQIA inspection.

Copies of three patients' written agreements were reviewed. The agreements set out the terms and conditions for residing at the home and were signed by the patients, or their representatives, and a representative from the home. The agreements showed the current weekly fee paid by, or on behalf of, the patients.

The manager confirmed that no patient was paying an additional amount towards their fee over and above the amount agreed with the Health and Social Care Trusts.

Records of fees received on behalf of two patients were reviewed; the amounts received agreed to the amounts assessed as owed to the home by the Health and Social Care Trust.

An appointee was in place for 18 patients, i.e. a person authorised by the Department for Communities (DfC) to receive and manage the social security benefits on behalf of an individual. Copies of written confirmation from the DfC for the member of staff to act as appointee were available for inspection. Records of the benefits received on behalf of two patients were reviewed. The records were up to date and confirmed that the benefits received were managed appropriately.

It was noticed that one of the appointees named on a number of patients' documents no longer worked at the home. Discussion with staff confirmed that the DfC had been informed of the situation, however, the home had not received a reply. The manager was advised to follow this up with DfC and to submit new applications with the DfC in order that the patients' appointee is a current member of staff. This will be reviewed at the next RQIA inspection.

A sample of purchases undertaken on behalf of patients was reviewed. The records were up to date at the time of the inspection. Two signatures were recorded against each entry in the patients' records and receipts were available from each of the purchases reviewed.

The manager was commended on the practice of completing consent forms prior to purchases undertaken on behalf of patients over a certain amount of money. The forms provided details of the proposed purchases. The outcome of discussions with family members and representatives from the Health and Social Care Trusts agreeing to the purchases were recorded on the forms.

A sample of records of payments to the hairdresser was reviewed. Records were up to date and signed by the hairdresser and countersigned by a member of staff to confirm that the treatments took place.

A sample of records of monies deposited at the home on behalf of patients was reviewed. Records were up to date at the time of the inspection. Receipts were provided to the person depositing the monies on behalf of the patient. A sample of patients' monies forwarded to the home from the Health and Social Care Trust was also reviewed. The amounts recorded as received on behalf of the patients agreed to the records forwarded from the Trust.

A sample of two patients' records evidenced that property records were in place for both patients. The records were not up to date with items brought into patients' rooms or when items were disposed of. The records were not checked and signed at least quarterly. This was discussed with the manager and identified as an area for improvement.

Comprehensive policies and procedures for the management and control of patients' finances were available for inspection. The policies were readily available for staff use. The policies were up to date and reviewed at least every three years.

It was noticed that the policy stated that items brought into patients' rooms by, or on behalf of, patients would be recorded in patients' records if the item was over a specified value. Any items below this amount would only be recorded if requested by the patient or at the discretion of the home. The manager was advised that any items brought into patients' rooms should be recorded in patients' records. The manager was also advised to review the policies to ensure that they are in line with the Care Standards for Nursing Homes (April 2015). The finance policies and procedures will be reviewed at the next RQIA inspection.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and/or the Care Standards for Nursing Homes (April 2015).

	Regulations	Standards
Total number of Areas for Improvement	0	3

Areas for improvement and details of the Quality Improvement Plan were discussed with Carmel Nelson, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 28 February 2022	The registered person shall review the frequency in which patients' pressure management risk assessments are completed to ensure the safe and effective monitoring of patients' skin. Ref: 5.2.2
	Response by registered person detailing the actions taken: Discussion on completion of Braden Scores at Nurse Meeting and care plan auditing will ensure complaince is maintained.
Area for improvement 2 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 31 March 2022	The registered person shall ensure that the mealtime menu offers a choice of meal for patients at mealtime. This should also include meal options for patients who require to have their meals modified. Ref: 5.2.2
	Response by registered person detailing the actions taken: The manager will ensure that choice is available to patients who require modification to meals and this will be identified on the menu.
Area for improvement 3 **Ref:** Standard 14.26 **Stated:** First time **To be completed by:** 31 March 2022	The registered person shall ensure that the patients' inventory of personal possessions is kept up to date with adequate details of the items brought into the patients' rooms. The records should be reconciled at least quarterly and signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff. Ref: 5.2.6
	Response by registered person detailing the actions taken: The patient inventory will be kept up to date with the details of new items brought into the rooms and reviewed on a quarterly basis. Care plan auditing will ensure compliance.

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

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