The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Beechill Care Home

Provider: Beaumont Care Homes Limited

Date of Inspection: 10 October 2024

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:	Beaumont Care Homes Limited
Responsible Individual:	Ruth Burrows
Registered Manager:	Ms Rosemarie Bautista – not registered
Service Profile – This home is a registered nursing home which provides nursing care for up to 34 patients living with dementia. The home is set over two floors and patients have access on each floor to a dining room and various communal lounge areas. There have been no changes in registration since the last inspection.	

2.0 Inspection summary

An unannounced inspection took place on 10 October 2024 from 9.30 am to 5.30 pm by two care inspectors.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

It was evident that staff promoted the dignity and well-being of patients, responding promptly and compassionately when patients asked for help. Patients said that living in the home was a good experience and they were well cared for. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Relatives described very positive experiences with the staff and the care provided for their loved ones and reflected that they were always made to feel welcome.

Could we consider “Care delivery was safe, effective, compassionate and well led. However; improvements were required to ensure staff fully adhered to safe moving and handling techniques. Please see Section 3.3.2 for further details.”

As a result of this inspection, one area for improvement was assessed as having been addressed by the provider. Other areas for improvement have either been stated again or will be reviewed at a future inspection. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

3.0 The inspection

3.1 How we Inspect

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

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patient's, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Patients spoken with told us that the care was "very good" and gave positive responses when asked about their experience living in Beechill. Patients who were unable to verbalise their experience were observed to be enjoying their time socialising with others and interacting with staff. Patients were seen to be comfortable, smiling and laughing with others throughout the day.

Relatives who spoke with us said "the care is second to none", "staff always welcome us with tea and we are made to feel very welcome". Relatives also reflected on the personal aspects of care given and said they felt that the staff knew their loved ones well.

Staff said there was "good team work" and "lovely people here". Staff were observed to be enjoying their job and find meaning in providing care, reflecting that they enjoyed the company of the patients and found the joy to be reciprocated. Staff said that they felt "very supported here".

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of patients. There was evidence of robust systems in place to manage staffing.

Patients said that there was enough staff on duty to help them. Staff said there was good team work and that they felt well supported in their role and that they were satisfied with the staffing levels. Staff were observed to respond promptly to patients. There was enough staff to provide activities and staff were observed to be working well together, assisting one another in providing person centred care at mealtimes. Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of individual patients' needs, their daily routine wishes and preferences. Some inconsistencies in written handover records were highlighted to the person in charge for action and review.

Throughout the day staff were observed to work well as a team and sharing aspects of care delivery to ensure person centred care. Staff were observed to be respectful to patients. Staff were aware of patient's individual choice and preferences and facilitated this; for example, where they wish to eat their lunchtime meal, or whether they liked gravy or not.

Staff were proactive in engaging patients in meaningful activity. For example, in addition to scheduled activities, staff looked through magazines with patients and were observed playing games with them. Patients were given choices as to how they wish to spend their day. The activities display indicated that there was scheduled activities throughout each day such as board games and puzzles, movie club, and fidget therapy. However, the information was difficult to read as the handwriting was small. This was discussed at the time with the person in charge. The staff are actively engaging in developing their display of activities and the programme. Therefore, this will be reviewed at a future inspection.

At times, some patients may require the use of equipment to assist them in moving from one room to another. It was observed that staff did not adhere to best practice in relation to safe moving and handling, and this required the inspector to intervene on one occasion. This was immediately addressed on the day by the management team. An area for improvement was also identified.

Patients living with dementia may require use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. It was established that safe systems were in place to safeguard patients and to manage this aspect of care.

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 may include simple encouragement through to full assistance from staff and their diet modified. Staff made effort to include relatives in some aspects of care such as enabling them to join in the dining experience, feeding their loved one. The menu display was not easily understood by patients in either of the dining rooms. The person in charge who gave assurances that there was current effort to source a pictoral display which could be more easily understood by patients. This will be reviewed at a future inspection.

3.3.3 Management of Care Records

Patients' needs were assessed by a nurse 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.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Nursing staff recorded regular evaluations about the delivery of care. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate. Care plans were both typed and hand written which was sometimes difficult to understand. When this was discussed the person in charge advised that there was a plan already in place to review the format of care plans.

Care records evidenced ongoing monitoring of patients if they had a fall, and staff updated individual patient's records each day with a reflection of the person's day.

Review of a selection of care records indicated that Speech and Language Assessments had not been updated accurately in the care plan or in other written means of communication such as the staff handover or the kitchen files. This area for improvement will be stated for a second time.

3.3.4 Quality and Management of Patients' Environment Control

The home was clean, tidy and well maintained. Patients' bedrooms were personalised with items important to the them such photographs and teddy bears. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. There were pictures throughout the home and paintings on the walls. There were also homely ornaments throughout the home creating an attractive environment. There were also magazines available for patients to look at if they wished.

The home's environment was welcoming and there were several sitting areas for patients or visitors to use for socialising. Communal areas were decorated seasonally, adding to the homely and welcoming atmosphere.

Staff were observed to use Personal Protective Equipment appropriately and there were multiple stations for hand sanitiser throughout the home. Staff were observed to be using these stations for opportunities for good hand hygiene.

3.3.5 Quality of Management Systems

There has been a change in the management of the home since the last inspection. Ms Rosemarie Beautista has been the manager in this home since 8 April 2024. Ms Beautista is in the process of applying to register with RQIA.

It was clear from the records examined that the manager had effective processes in place to monitor the quality of care and other services provided to patients. There was evidence that there were routine checks on the quality of care delivered and any actions identified were addressed.

Relatives spoken with said that they knew how to report any concerns and said they were confident that the Manager would address their concerns.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	*2	*1

The total number of areas for improvement includes one regulation that has been carried forward for review at the next inspection. One standard has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with the person in charge 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 Nursing Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref:** Regulation 12 (b) **Stated:** First time **To be completed by:** 10 October 2024	The Registered Person shall ensure treatments and services provided to each patient reflect current and best practice. The registered person will monitor staff and ensure safe moving and handling is embedded into practice. Ref: 3.3.2
	Response by registered person detailing the actions taken: Individual residents care plans, risk assessments and Moving & Handling Profiles have been reviewed. The profiles are displayed in each bedroom for ease of access. Staff are made aware of any changes in individual resident's condition and plan of care during handover at start of each shift. Flash Meetings and Clinical Supervision sessions were held between 10th - 17th October 2024 and staff meetings were also held on 22nd & 24th October 2024 for all Trained and Care staff to discuss the inspection findings, company policies, moving & handling records and accountability. Moving & Handling update training was completed with all Trained and Care staff on 22nd & 24th October 2024. Walkabout Audit has been updated to include moving & handling observations for further monitoring, these are completed by Trained staff, Deputy Manager or Home Manager. Care plans and risk assessments are reviewed on a minimum of monthly basis or whenever there is a change in a resident's care needs. Moving & handling observations will be completed by Operations Manager during visits to the Home.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 2 February 2024	The registered person should ensure that liquid medicines are accurately measured and administered in accordance with the prescriber's direction. Ref: 5.1
	Action required to ensure compliance with this Regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.

Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)

Area for improvement 1 **Ref:** Standard 4 and 12 **Stated:** Second time **To be completed by:** 10 December 2024	The registered person shall ensure that care plans are re-written when significant changes occur in a patient's nutritional need. This is with specific reference to choking risks and International Dysphagia Diet Standardisation Initiative (IDDSI) recommended levels. Any changes in nutritional needs must be updated and shared in writing with the catering team. Ref: 3.3.2
	Response by registered person detailing the actions taken: An audit has been completed for each resident which cross referenced their individual care needs with their care plan, food & fluid chart, choking risk assessment and dietary notification to ensure all recommendations are correct. A review has been completed of each residents Diet Notification held by catering team to ensure they accurately reflect their care needs. All care files have also been reviewed to ensure correct IDDSI prescription forms and descriptors are in place. REDS folder has also been reviewed to ensure up to date copies of IDDSI/SALT recommendations are in place for each resident requiring a modified diet. Clinical Summary has been reviewed and cross referenced with each residents SLT and Dietetic recommendations. Supervision has been completed with all trained staff regarding the importance of updating care records and providing an updated Diet Notification to catering staff when changes are made for individual residents IDDSI levels. A rolling 10% of all care records will be audited on a monthly basis by the Home Manager to ensure information is cross referenced correctly. Operations Manager will sample records during monthly Reg 29 visit.

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