Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Beverley Grange Nursing Home

Lockwood Road, Molescroft, Beverley, HU17 9GQ

Tel: 01482679955

Date of Inspection: 28 February 2014

Date of Publication: March 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Records ✓ Met this standard

Details about this location

Registered Provider	Molescroft Nursing Home (Holdings) Limited
Registered Manager	Ms. Christine Wright
Overview of the service	Beverley Grange is a purpose built home situated on a housing development in a residential area on the outskirts of Beverley. The home is set in its own grounds with plenty of space for people to sit and enjoy the fresh air. The home was opened in 1999 to provide long term and respite stays, looking after older people who need residential care or nursing care.
Type of services	Care home service with nursing Care home service without nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Beverley Grange Nursing Home had taken action to meet the following essential standards:

- Records

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 28 February 2014 and talked with staff.

What people told us and what we found

We undertook this visit to review the areas of non-compliance found at the previous inspection. This was in relation to records and record keeping in the home.

We did not speak directly with people who lived in the home as we were following up on the previous inspection when people's views had been incorporated into the judgments at that time. No comments had been received in relation to documents or paperwork.

We found that the provider had taken action and previous issues in relation to care files had been addressed. Records were more person centred, care plans included all areas of need and monitoring forms were on the whole up to date. With only minor work now required to ensure that all details were recorded.

Staff files were more detailed and information recorded in the staffing matrix cross referenced with that held in individual files.

We saw some documents in relation to the management of the home and these were up to date.

Records were stored securely with only minor improvements required to help ensure that data was fully protected.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Records ✓ Met this standard

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

People's personal records including medical records were accurate and fit for purpose.

We undertook this visit to review areas of non-compliance found at the last inspection. This included that care plans required improvements, they were not all person centred, did not include sections for diagnosed medical conditions, for example, diabetes and did not hold detailed records in relation to peoples likes and dislikes or moving and handling needs. Staff training records also required improvements, this included that the information held on individual records did not always match that held on the staff training matrix and that the information on the staff training matrix was not comprehensive.

We did not speak directly with people who lived in the home at this inspection as we were following up on the previous inspection when people's views had been incorporated into the judgments at that time. We did speak with one relative who told us that overall they were happy with the support offered in the home.

We observed interactions between staff and people who lived in the home and saw that these were polite and respectful. In one instance a member of staff was encouraging someone with their dietary intake and they were kind and compassionate with this person. We also noted that people were able to choose whether to spend time in their own room or the communal areas of the home and that people appeared relaxed.

The provider told us about some of the changes in the home and that this included allocation of staff time to review care plans and records in the home.

We looked at a variety of care plans which covered the support offered for people with different levels of need. This included people who lived in the bungalow areas of the home, those who lived in the residential areas of the home and for those people who lived in the nursing areas of the home.

We saw that all of the files were now in the new format commenced at the last inspection

visit and the majority were now more personalised. They included details of the person's medical and life history, contact details of the person's next of kin, details of the person's abilities, records of other professionals input, risk assessments and support with moving and handling, including which equipment was to be used. We saw that specific care plans were in place which covered a variety of areas of need and included people's medical conditions. Records were regularly reviewed although the provider may wish to note that the details of these were more person centred in records for people living in the non nursing areas of the home.

We found that care files and records were comprehensive and only minor improvements were now needed and that this related primarily to nursing records. For example, we saw that when a schedule of monitoring of a person's need had been amended the staff had responded and followed the new instruction but the care plan had not always been amended.

We also looked at staff training records and the training matrix and saw that work had been undertaken to improve these. The training matrix was more comprehensive and included more information for each staff member. It recorded which courses people had attended, these included the safeguarding of vulnerable adults (SOVA), moving and handling and fire training. The information recorded either the date the course was completed or the date it was due to be completed. However, the provider may wish to note that as these were all recorded in the same format and in the same sections it would be difficult to monitor when people had actually completed courses or if the planned date simply remained on the matrix.

We also looked at individual staff training records and saw that each staff member had a summary sheet which recorded the courses they had attended. The majority of these details now, matched the information recorded on the matrix and only minor work was now required to complete this work. Training certificates or course work was also in staff files and these matched the courses recorded as completed. In discussion with the provider, registered manager and training person they informed us about the plans they had to complete this work further which included the development of a new system to enhance the training records.

We reviewed records for other systems in the home and this included policies and procedures, complaints and accident records. We saw that a professionally designed set of policies were used in the home that had been purchased by the provider. These were extensive and held in four separate folders. They all had a recorded review date of 2010 and the provider may wish to note that only one folder had evidence of review, consequently it was unclear whether these provided the latest and correct guidance to staff.

The manager provided us with the complaints folder which had been updated since our last visit. Recent complaints were in relation to staff matters and the provider had investigated these through their human resource systems.

Accidents were all recorded both in individual files and electronically. We saw that individual records included the necessary details in relation to the person, the accident and any injury. However, the section for the manager to confirm they had reviewed this information was not completed.

We undertook a tour of the premises to review the storage of personal records. We saw that there was a designated area in the home with lockable storage and although these

were closed to protect information, not all were locked. The provider may wish to note that this would not fully restrict unauthorised access to records to protect people's personal data.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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