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: 19 November 2013

Date of Publication: December 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✗ Action needed

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

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

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 19 November 2013, observed how people were being cared for and talked with people who use the service. We talked with staff, talked with commissioners of services and talked with local groups of people in the community or voluntary sector.

What people told us and what we found

We undertook this inspection to follow up on previous areas of concern in relation to records in the home regarding people's care, staff training and supervision, quality assurance in the home and overall record keeping.

People who lived in the home told us "I am very satisfied" and " I am glad I came here" when asked about life in the home. They confirmed staff were polite and we observed appropriate support being offered to people. One person confirmed they had been asked to complete a questionnaire about life in the home.

We found that the provider, manager and staff had undertaken a large amount of work in response to our concerns. However additional work was still required.

A new system of care planning had been implemented to help ensure that all of a person's needs were recorded and supported.

New staff training records both for individual staff and an overall matrix had been updated and supervision sessions had taken place.

Maintenance records were now in place; as were risk assessments.

However improvements continued to be required as care plans did not all contain all of the relevant information and staff training record details did not match the matrix.

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

What we have told the provider to do

We have asked the provider to send us a report by 27 December 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is

taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

We undertook this inspection to follow up on previous concerns. At the last visit to the home we found that care files did not include comprehensive information and did not include all of the necessary details. Records including monitoring forms were not always fully completed.

Since the last inspection we have liaised with the commissioners of the service and the local health and safety officer following concerns raised as to the use of equipment within the home. There is a separate investigation being undertaken by the Health and Safety officer and any recommendations from this will be dealt with under the appropriate legislation. Initial conclusions have identified inconsistencies in moving and handling care plans and are being addressed with the home.

People who lived in the home were positive in their responses regarding the home. Comments included "I think the home is well run and I am confident that if I raised any concern the manager would deal with it." And "I am very happy with the support and everyone is kind and helpful." People told us that staff were polite and knocked on the door before entering their room with one person stating "I am glad I came here." And "I am very happy with the support and everyone is kind and helpful."

At this visit we looked at the care files for several people, some of whom required nursing care in the meeting of their needs. We saw that new care plans had been developed for the majority of the people who lived in the home and we received assurance that the remaining care plans would all be updated within a two week period post this visit.

We saw that the new care plans were well organised and covered a variety of areas for each person. An admissions information sheet had been completed which recorded the

persons past and present medical history, their reason for admission and personal details, for example, their next of kin. An admissions assessment had also been completed for a variety of areas of need which included communication, hygiene, moving and handling, tissue viability and social needs. This information had then been used to develop the persons' plan of care. The information recorded provided advice to staff on how to support the person with their latest assessed needs.

Risk assessments had been completed to identify any areas of risk and the actions to be taken to support the person to live their life safely. We saw this included a moving and handling risk assessment and bed rails risk assessment. We saw that some care plans included the details of the moving and handling equipment to be used. However the provider may wish to note that this was not the case for all of the care plans reviewed.

There was evidence in people's files that they received support from other professionals in the meeting of their health needs. These details included the GP, chiropodist, dietician and the falls team. Monitoring forms were in place to assist in meeting people's health needs. We saw recorded that one person had been supported when they had recently fallen. The staff had taken appropriate action and liaised with the GP, they ensured that any changes had been recorded in the persons' care plan.

Daily diary notes had been completed by the staff to record the support offered and daily activities of each person.

However the provider may wish to note that we saw that improvements continued to be required in order for people's records to accurately and fully record all of the persons needs. For example, one person did not have a care plan regarding their diabetes, one person's information had not been recorded on their risk assessment, details of one persons' hoist were not comprehensive and daily diary notes were not person centred.

The new care files included a section for a review of care every six months and we saw some evidence that the care plan had been reviewed on a monthly basis. This helped to ensure that staff were aware of the latest needs of the person.

We observed the interactions between the staff team and people who lived in the home. We saw staff support someone with the use of a hoist and this was correctly completed. We observed that staff talked to the individual throughout the process keeping them informed. We also observed staff support one person with having a drink, they were patient and pleasant with the person.

Activities took place throughout the day and involved several people who lived in the home and the staff team. People appeared to enjoy this time and again interactions with staff appeared positive.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

Staff were able, from time to time, to obtain further relevant qualifications.

We undertook this inspection to follow up on previous areas of concern. At the last visit we found that the staff induction did not include all of the required information, the training matrix, nurse training and supervision sessions were not up to date.

We were told that no new staff had commenced employment in the home since the last visit. However a new induction pack had been developed. This was comprehensive covering a variety of areas.

We were told that the provider was continuing to develop the staff training matrix and we were provided with the latest version of this. The information recorded that from 34 staff 32 had completed training in moving and handling; 19 of these were in the last year. It also recorded that 11 staff had completed Dementia care training, 20 had completed First aid training and Fire awareness training. We saw that the majority of care staff were recorded as having achieved a National vocational Qualification (NVQ) at level 2 or above. However only two staff had fully completed infection control training (several had commenced this) and only six staff had completed Mental Capacity Act training.

Although staff records had also been updated we saw that improvements continued to be required with these. This included evidence that the induction met skills for care requirements, that the staff training matrix and individual files contained the same information and that supervision contained detailed information.

The provider may wish to note that the only nurse specific training we saw recorded was wound care and for the use of the syringe driver.

The provider may also wish to note that two people were not recorded on the staff training matrix and their records indicated that they had not undertaken any training.

We looked at the supervision records for staff and saw recorded that supervision was taking place on a regular basis. Training was discussed as part of these supervision

sessions.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.

We undertook this inspection to follow up on previous areas of concern. At the last visit we found that audits were not fully completed and maintenance records were not in place.

At this visit the manager informed us that quality assurance questionnaires had recently been sent to people who lived in the home and to visitors; they were awaiting the return of these. One person who lived in the home told us they had received one of these questionnaires. This helped people comment on the standards within the home.

Audits had been commenced by the manager of different systems in the home and this included administration, training, health and safety and the kitchen; there was an action plan from previous audits. This helped ensure that systems were checked to ensure that they were to the required standard.

We saw that records were kept of the maintenance of systems in the home. Regular maintenance helps to ensure that people live in a homely and safe environment. Records included a five year electrical wiring certificate which recorded the safety of the electrical systems in the home and also a gas safety document. The provider confirmed that all recommendations from previous inspections of the gas system had been completed. Checks of the fire safety systems had been undertaken and these included the emergency lights and fire extinguishers. Maintenance checks had also been completed on hoists used in the home.

Records were kept of accidents in the home. The provider may wish to note that not all of these recorded that the manager had reviewed the accident or if any additional follow up action was required.

We saw there were risk assessments to help keep people safe; these were in relation to the environment and some of the equipment in the home. A Legionella risk assessment

was in place and recent testing had taken place; the manager forwarded the outcome of this to the CQC. Risk assessments in relation to the use of bed rails were not place and the manager confirmed this was due to all bed rails being integral to the bed.

Records were also kept of any complaints made to the home including the actions taken and responses made.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People's personal records including medical records were not accurate and fit for purpose. Staff records and other records relevant to the management of the services were not always accurate

We undertook this inspection to follow up on previous concerns. A the last visit we found that both records for staff and people who lived in the home were not adequately completed and kept up to date, with some records being stored in a communal area.

At this visit the manager confirmed that a large amount of work had been undertaken in response to the previous concerns raised. This included that the access to the storage areas for records was now lockable and that care plans and staff training documents had been reviewed and updated.

We looked at peoples care plans and saw that the majority were in a new format with plans in place to ensure that all care plans were transferred to this. All of these included up to date information in relation to the individual person and their needs. Although comprehensive the new care plans did not always cover all of the areas of need for the person. For example although recorded as a need there was not an individual care plan to support someone in managing their diabetes. The provider informed us that this was addressed in the persons other care plans. Additional work was required to ensure that these were comprehensive and personalised. For example, people's likes and dislikes were recorded but this was not detailed.

We saw that some care plans included the details of the moving and handling equipment to be used. However this was not the case for all of the care plans reviewed, for example, one file recorded the use of the hoist but not the colour of the sling to be used. The provider informed us this information was in the persons' room. However this information should be clearly recorded in the persons care plan.

Additionally we saw monitoring forms for people's health needs, again these required more

detail. We saw where one person had been supported after a fall; information regarding this was recorded in thier care plan but the details had not been transferred into their risk assessments.

Daily diary notes had been completed. However the style of these records had changed and was now less person centred.

The staff training matrix recorded some of the courses people had attended. However, it did not record all of the courses attended or the expiry/renewal date of the courses completed.

We looked at peoples' individual training records and saw that their individual training matrix recorded additional training to that recorded on the overall training matrix.

Details of training dates did not always match individual staff training records and no actions plans for future staff development were held in staff files; records were not detailed.

Although there was a new induction package there was no evidence that this met the skills for care guidance, which is a nationally recognised standard.

We also saw that no training had taken place with staff regarding information governance.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: Regulation 20. The provider must ensure that service users are protected against the risk of unsafe or inappropriate care and treatment arising from a lack of proper information about them.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 27 December 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

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.

Contact us

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