Techscheme Limited

Bluebell Nursing Home

Inspection report

45-53 St Ronan's Road, Southsea, PO4 0PP
Tel: 023 9282 3104
Website: www.example.com

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Ratings

Overall rating for this service	**Good**
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the home.

The inspection was unannounced.

Bluebell Nursing Home provides accommodation for up to 51 people who require nursing, respite or end of life care. Some of the people being cared for at Bluebell were living with dementia. At the time of our inspection there were 48 people living at the home. The accommodation was arranged over three floors and there are lifts available for accessing the each floor. The home offers single and double rooms, most with private en-suite facilities.

The home had a registered manager in post that was responsible for the day to day running of the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home and has the legal responsibility for meeting the requirements of the law; as does the provider.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. There were three people living at the home who were subject to a DoLS. The

Summary of findings

manager had followed the relevant application processes and any conditions made by a supervisory body to ensure people who were being deprived of their liberty were authorised and safe. Staff understood the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS), and put them into practice to protect people.

People were protected from abuse and avoidable harm and people told us they felt safe in the home. One person said, "I can relax here." A relative told us, "I trust them completely to look after Mum here." Healthcare professionals said they would be happy for their relative to live at the home."

There were sufficient staff to meet people's needs and provide people with individualised care. We found all staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns. Risk assessments and management plans had been completed when people experienced behaviour, which may challenge others. Medicines were administered safely to people. All checks were completed to ensure only staff who are suitable and safe to work with vulnerable people are employed.

People were supported by staff who had the necessary skills and knowledge to meet their assessed needs. People had enough to eat and drink throughout the day and night if required and steps were taken to identify and support people who were nutritionally at risk. People were supported to have access to healthcare services, such as podiatry, GP's and dentists, and were involved in the regular monitoring of their health.

People, relatives and health and social care professional told us staff were friendly, kind and caring. One relative said, "Staff are attentive, and really respect residents." Staff involved and treated people with compassion, kindness, dignity and respect. Interactions between staff and people were kind and respectful. People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes and people's privacy and dignity were respected and promoted.

People's needs were assessed and care plans were regularly updated to reflect changes in need. Staff on duty used a Digital Care System (DCS) to inform them when people required support. There were a range of activities available to protect people from social isolation and give them a choice of activities to take part in. People told us if they had any issues they would speak to the director or the registered manager and something was always done about their concerns. Relatives responded positively about the home and said they would not change anything.

There were effective systems in place to monitor and improve the quality of the service People, staff, health and social care professionals and visitors all told us the home was friendly and management were always visible and approachable. Staff were supported to question practice and they told us they would report any concerns. The home had a system to manage and report incidents, and safeguarding concerns and CQC had been notified of these concerns. A quality assurance system was in place which helped the management team assess people's experiences of care they received and observed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The home was safe. People were protected from abuse and avoidable harm. People told us they felt safe Staff had a good understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place.

The home had policies and procedures in relation to the Mental Capacity Act (MCA) 2005 and we saw the home had a copy of the MCA 2005 Code of Practice. All staff had received training in the MCA 2005 and demonstrated a good understanding of this and the Deprivation of Liberty safeguards (DoLS).

Risk assessments had been completed when people experienced behaviour, which may challenge others. Management plans were in place and staff managed these behaviours in a positive way which protected people's dignity and rights.

There were sufficient staff numbers to meet people's needs and provide person centred care. All checks required to help ensure only staff who are suitable and safe to work with people are employed.

Medicines were administered safely to people.

Is the service effective?

Good

The home was effective. People were supported by staff who had the necessary skills and knowledge to meet their assessed needs. The staff team had worked at the home for a number of years which helped to ensure care was delivered in a consistent way as staff were familiar with the needs of people.

People had enough to eat and drink and steps had been taken to identify and support people who were nutritionally at risk.

People were supported to have access to healthcare services, such as podiatry, GP's and dentists, and were involved in the regular monitoring of their health. Staff worked effectively with healthcare professionals and was pro-active in referring people for diagnosis and treatment.

Is the service caring?

Good

The home was caring. People told us staff were friendly, kind and caring. Health and social care professionals said, staff were professional, kind and courteous. People's relatives and friends were able to visit at any time.

Interactions between staff and people were kind and respectful. Staff were happy, cheerful and caring towards people and their relatives.

People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes and people's privacy and dignity were respected and promoted.

Is the service responsive?

Good

The home was responsive. The home was organised to meet peoples changing needs.

Summary of findings

People's needs were assessed upon admission and care plans were regularly updated to reflect changes in need. An innovative portable IT system meant that staff were able to respond quickly and effectively to people's nursing needs.

There were a range of activities available to protect people from social isolation and give them a choice of activities to take part in which had been developed based on people's likes and preferences.

There were plans to make a number of changes to improve the environment and people and their relatives were involved in the decision making process.

Relatives and people responded positively about the home and said they would not change anything. People told us they felt listened to and concerns raised to management were always dealt with.

Is the service well-led?

Good

The home was well led. The leadership and management of the organisation assured the delivery of high quality personalised care that supported learning and promoted an open culture.

People, staff, professionals and visitors all told us the home was friendly and management were always visible and approachable. Staff were supported to question practice and they told us they would report any concerns.

There was an effective transparent system to manage and report incidents, safeguarding concerns which ensured that relevant external bodies were informed.

A quality assurance system was in place to monitor the quality of the services and facilities provided.

Bluebell Nursing Home

Detailed findings

Background to this inspection

An inspection was undertaken on the 16 July 2014. The inspection team consisted of an Adult Social Care inspector, and an expert by experience who had a nursing background. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We spoke with Care Commissioning Groups (CCG) and the Local authority safeguarding team to obtain their views on the home and the quality of care people received.

On the day of the inspection we spoke with 19 people who were living at the home. We also spoke with four relatives, two nurses, five care workers, one member of the nursing team, two catering staff, three professionals that included, two dental assistants and a practice nurse who visited the home, the activities co-ordinator, training officer, the registered manager and the director.

We observed care and support in communal area's including the dining room. We looked at ten peoples bedrooms and spoke with people about the care and support they received. We reviewed a range of records about people's care and how the home was managed that included the care plans for five people, training and induction records for all staff employed at the home, five people's medicine records and the quality audits the home completed.

Where people were unable to speak with us due to their complex needs, we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) over the lunch time period. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

The last inspection of this home was in November 2013 where no concerns were identified.

Is the service safe?

Our findings

One relative told us, "I trust them completely to look after mum here." Staff we spoke with showed an understanding on how they could keep people safe. For example, ensuring people have the right equipment and regular food and fluids. We spoke with the local authority safeguarding team and they told us they did not have any concerns about the home.

There were policies and procedures for managing risk and staff understood them. Staff had received training on safeguarding and protection of vulnerable adults (POVA). Staff confirmed they had received training in safeguarding and demonstrated an understanding on how to recognise and respond to possible abuse. Staff understood their responsibility to report any concerns and were aware of the importance of disclosing concerns about poor practice or possible abuse.

We looked at the training plan and saw staff had received training on the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff understood the requirements of the MCA and DoLS, and put them into practice to protect people. For example, a mental capacity assessment had been completed for a person who was considered to lack capacity to consent to and understand the care being provided. The person would become physically aggressive towards staff when care was being carried out and would shout and harm themselves. A best interest meeting took place and an application was made to the Local Authority for the use of minimal restraint which was necessary to protect the person and staff when care tasks were being completed.

When people experienced behaviour, which may challenge others, behavioural risk assessments were in place and reviewed regularly. Staff managed the situation in a way that protected people's dignity and rights. The registered manager told us two people required the use of low level physical restraint to assist with the completion of personal care due to aggressive behaviour towards staff whilst this task was being carried out. One person lacked capacity to understand the reason for why restraint would be used and was subject to a best interest decision and a DoLS authorisation. However one person was deemed to have capacity to understand when physical restraint was required. The registered manager told us this method was not used every time and staff we spoke with confirmed they had been trained on how contact needed to be used. Staff confirmed the procedure to follow for these people and were aware physical restraint was not always necessary for both people.

Where people were identified to be at risk, risk management plans were in place and staff followed them to prevent people's choice and freedom being restricted. For example, a behavioural chart was present on a person's record to help manage their behaviour and prevent the use of the need for restraint. The plan requested staff explained to the person what was happening to ensure the person did not feel out of control. However in the event of the person becoming aggressive plans were in place for staff to use light restraint by holding the persons hands or placing a sheet or a towel over them at five minute intervals. Staff we spoke with demonstrated knowledge of this person's risk management plan.

Safe recruitment practices and appropriate pre-employment checks were completed prior to new staff starting at the home. All staff we spoke with confirmed they had completed a Disclosure and Barring Service (DBS) check and references were obtained. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with people who use care services. Checks had been completed to ensure nursing staff were registered with the Nursing and Midwifery Council (NMC). The NMC ensures nurses provide a high standard of care by setting professional standards for nurses to keep their skills and knowledge up to date.

There were sufficient and competent staff on duty with the right skill mix to make sure practice were safe and they could respond to unforeseen events. Staff told us on each floor one care worker had the responsibility for responding to people's nutrition and hydration needs and ensuring they were frequently turned and checked. The home had some staff vacancies and used the same agency to support staffing levels. This meant the agency staff were well known to the people and ensured consistency.

There were clear procedures for supporting people with their medicines. The registered manager told us all people living at the home required support with their medicines. The registered manager told us nurses were responsible for administering medicines. Care staff confirmed they did not give medicines as it was the responsibility of the nurses. A trained nurse was administering medicines on the second floor of the home and the medicines were stored in a

Is the service safe?

locked trolley in a designated area and in individual blister packs. Controlled medicines were stored on the ground floor in a coded room in a locked cupboard. Medicines were recorded on a medicines recording (MAR) chart. Medicines were disposed of using yellow medicines disposal boxes and were removed each month by the clinical waste team. Records of all disposed medicines were kept.

Appropriate documentation was in place for people who required their medicines to be crushed. For example, where two people required their medicines to be crushed due to swallowing difficulties, GP letters were present on their files. For one person the GP had authorised for all their medicines to be crushed and for another person one medicine had been changed to a liquid form and another medicine was authorised to be crushed.

Is the service effective?

Our findings

Staff had the necessary skills and knowledge to support people and meet their assessed needs. People told us staff supported them with their needs and felt staff knew them well. People told us staff would always ask how they would like their needs met each time support was required. We completed a SOFI observation over the lunch time period and observed staff were aware of people who required additional support with their meals. The support varied dependent upon the person's assessed need. For example, one person's meal was cut up and they were able to eat this meal on their own. Another person's meal was cut up and they required support to be fed.

Staff told us they had completed a three day induction course when they started working at the home which included shadowing experienced staff before they were able to work alone. A full time training officer was responsible for carrying out all required training such as, mental capacity and DoLS, manual handling and safeguarding. The training officer had enrolled eight care staff in the health and social care diploma. They said, "Any training is welcome, internal, external." Staff confirmed they received regular training updates and could request additional training when it was necessary. Staff records confirmed staff had attended regular training on safeguarding, manual handling and MCA 2005. Plans were kept by the training officer to ensure staff skills and knowledge were regularly updated.

We spoke with the local Health Care Commissioning Group (CCG) who send a practice nurse assessor to the home to ensure nursing staff are keeping their skills and knowledge up to date. They told us they had no concerns about the practice of staff and felt they were all suitably skilled and experienced to meet people's needs.

Staff told us they felt well supported in their role. Staff were receiving regular supervision in line with the organisation's supervision policy. Discussions in supervisions considered staffs development and training needs and also discussed personal care, infection control, moving and handling and documentation. Formal clinical supervision was being undertaken for the nursing staff.

The majority of staff we spoke with during our inspection had been employed at the home for some time which meant staff retention was good and supported the delivery of consistent care by staff who were familiar with the needs of people. One member of staff told us, "I have been working here for 35 years, I love it and I know all the residents really well." We observed staff actions and attitudes towards people and other staff members and they were appropriate and timely, with an evident 'team spirit'.

People had enough to eat and drink throughout the day and night if required. One person told us, "They are always making sure I am drinking." Staff who worked on the night shift confirmed they regularly offered drinks to people who were awake during the night. Drinks were readily available throughout the day. We observed every person had fluids, in suitable drinking containers for their needs, provided in their rooms that were within reach. We saw drinks were also provided in the lounges, garden tables, and individually on the dining tables. We heard people being given a choice of drinks. A fridge was kept stocked in the dining room with fresh fruit juices, home-made milkshakes and yoghurts which people were able to freely access. Food and fluid charts were in place and updated regularly by the care worker responsible for this role. The director told us each resident would have a snack box in their room which was filled up daily by staff. Snacks in the box were dependent on the individual's dietary requirements.

We were told in the Provider Information Return (PIR) a mobile trolley 'shop' had been introduced which visited people in their rooms twice weekly to provide an opportunity to have confectionary or personal hygiene items. Different types of confectionary, hair nets and other personal hygiene items were available. The activities co-ordinator told us people "loved" the mobile shop trolley and it was free to people. People confirmed they liked having the mobile shop trolley as it felt like they were having a 'treat'.

People were consulted about their food preferences each day and were given options from the menu. We saw a care worker would visit each person in the morning and ask them what they wanted for breakfast. Considerable choice of breakfasts and meals were available. We observed if a person did not like or want anything from the menu the chef would ask them what they wanted and go to the shop and get it for them. One person said, "He gets to know my likes and dislikes, as I'm awkward to feed." One member of

Is the service effective?

staff said, “The chef is always coming and going to the shop and coming back with all sorts of things.” Relatives told us they often joined their relatives for lunch in the dining room, and praised the quality of the food.

The home had taken steps to identify people who were nutritionally at risk. People who were at risk of malnutrition were given a choice of freshly made milkshakes which were readily available. Menu tick sheets identified if a person required thickened fluids. People’s records showed healthcare professionals, such as dieticians had been consulted and informed nutrition care plans. We saw food, fluids and weight charts were being completed for people and we observed a person being taken to be weighed.

People were supported to have access to healthcare services and were involved in the regular monitoring of their health. Staff worked effectively with healthcare professionals and was pro-active in referring people for diagnosis and treatment. We saw a practice nurse visit the home and carry out annual reviews for some people, which included blood tests and an overall health check. We spoke with this professional and they told us, “Residents are well looked after and staff are very helpful.” We spoke with two dental assistants who had visited people in the home and they told us they had no concerns with the dental hygiene of people who were living at the home. Both dental assistants told us it was “A lovely home” and they would be happy for their relative to live at the home.

Is the service caring?

Our findings

People, relatives and professionals were positive about the care and support received from staff. We received comments such as, "Staff are excellent, friendly." "Never too much trouble"and"It's a really friendly home and lovely environment." One relative said, "They couldn't have been kinder to my parent when they moved in. I can't fault the care here. I'm here all the time, a bit of a fixture. I can make myself a cup of tea and all the staff know me and I know them. Such a relief." One person said, unprompted, "They're very kind and understanding." Another resident praised the staff and said, "It's the friendliness that's so nice, they really try to please you."

We observed interactions between staff and people which were kind and respectful. We saw staff were happy, cheerful and caring towards all the people and their relatives. The director told us the value of the home was, "To provide a lovely atmosphere that is friendly, supportive and provides good quality person centred care." All staff we spoke with were aware of these values.

People's preferences, likes and dislikes had been recorded and we saw support was provided in accordance with people's wishes. We observed two staff members visit a person's room; they asked them if they were ready to receive personal care and waited for a response from the person before carrying out the personal care tasks. We could hear staff speaking with the person whilst completing the personal care and making sure they were happy and comfortable with the support being given.

People told us they felt involved in their care. One person said, "Staff always asks me how I want my care given to me." Another person said, "If I have any problems with my care I ask staff to tell the manager I want to see them and they always come and listen to me and fix the problem." One Staff confirmed they gave people a choice on how they want their care to be given. One member of staff said, "We ask what the resident wants, they may not want to get out of bed, but we ask them and give them a choice."

We completed a SOFI observation during the lunch time period to observe staff interactions with people. Staff were kind, person-centred and attentive to people and their needs. We observed staff asking people how they were and engaging with them in a positive way. There was lots of laughter and one person was singing along to the radio. One member of staff came into the dining room towards the end of the lunch time period and they spoke with people and asked how they were and sat with people who were happy for them to do so. People were given a different choice of meal if they did not want the meal they had previously requested. There were sufficient staff during the lunch time period which meant people who required additional support could be given this at the right time and right pace for them. People were unrushed and those able to do so were able to walk around unsupported and speak with other people and staff.

People were encouraged to take part in residents' meetings where they could express their views about the home and the care they received. We saw minutes of meetings from 6 March 2014 and 25 April 2014 and noted people and their relatives attended the meetings. Agenda items focused on the décor of the home, activities and catering which included feedback from people and relatives. For example, we noticed a discussion had taken place in the March 2014 residents' meeting people would like to have flowers on the table. We saw that flowers were present on each table.

People's relatives and friends were able to visit at any time. On the day of inspection a number of relatives and friends visiting the home. We looked at the visit book which confirmed a large number of visitors come to the home each day. One relative said, "Staff are attentive, and really respect residents. I'm here every day and I'm very happy with the care here. They are really good."

People told us staff respected their privacy and dignity. Staff confirmed how they made sure people's privacy and dignity was respected. For example, by knocking on doors before they enter and closing their bedroom doors and curtains before commencing with personal care tasks. We observed care and nursing staff ask to enter the person's room when personal care or medicines were required.

Is the service responsive?

Our findings

People's needs were regularly assessed and their care plans were updated. The registered manager told us needs assessments were completed when people were admitted to the home. This was done over a period of time with the person and or relative to ensure the assessment accurately reflected the person's needs. Once people's needs had been assessed this information was transferred to a portable computer system known as a Digital Care System (DCS) which informed staff when people required support.

This system was developed by the director of the home to be responsive to people who were more at risk of dehydration or pressure sores and required regular monitoring. The DCS was updated by the carer or nurse each time care was given and vibrated when a person required repositioning and monitoring. Staff told us it was an effective and responsive system which meant people could get the care they needed when they needed it. One staff member said, "It is much more responsive than paperwork". Call bells were also present in each room and we heard they were responded to in good time. People confirmed staff provided them with the support they needed. This meant the home was flexible and responsive to people's individual needs and preferences.

There were a range of activities available to protect people from social isolation and give them a choice of activities to take part in. A full time activities co-ordinator was employed who co-ordinated, organised various events each month. This included singers, accordionists, guitarists, and "Mature Movers" exercises each fortnight. Occasional outings were also undertaken which included visiting a local lake to watch the boats and eat ice creams.

The activity co-ordinator demonstrated on their handheld computer the history of various events, minutes, and photographs taken. We saw photographs were displayed on a board of various social activities within the main entrance of the home. The activities co-ordinator told us, "Those residents that cannot attend the activities out of their rooms can if they wish have the entertainer do a one–to-one performance for them." All people and relatives spoke positively about the activities at the home and confirmed they were able to suggest activities to do. Feedback was gained from people after the activity had taken place and this was done in the theme of a quiz. The activities co-ordinator told us they used the feedback to help people extract the best motivational value and enjoyment from each occasion.

The director told us they were planning to make a number of changes to improve the environment. They also told us they wanted to make some changes to the layout of the lounge. We found in the residents' meeting minutes on 6 March 2014 people and relatives had been engaged in discussions concerning the removal of a lounge wall. We saw there had been an initial informal chat about dividing the lounge into two separate rooms with individual access. We noted this was highlighted as a priority and comments and suggestions were welcomed by management.

People told us if they had any concerns they would speak to the director or the registered manager and where they have had cause to do this, there concerns were always addressed. We asked people and relatives if there was anything they would change about the home . They all responded positively about the home and said they would not change anything. We saw complaints received were dealt with in a timely manner and in line with their complaints policy.

Is the service well-led?

Our findings

People, staff, dental practitioners, practice nurse and visitors all told us the home was friendly and management were always visible and approachable. One professional said, “Management are always welcoming.” Two people mentioned the manager by name, saying how “lovely” they were. Staff and people told us if they had any issues they knew the registered manager and director would try their best to resolve the problem.

Meetings were held regularly with people to discuss the developments within the home and the activities people would like to do. We saw the home was undergoing building work at the time of our inspection and people told us they had been involved with the design of the home.

There was a registered manager in post at the time of our inspection who was also trained as a registered nurse and was responsible for the day to running of the home. Staff told us management was very good and very supportive and supported staff to question practice. One member of staff said, “You never feel like you can’t ask anything.” Another member of staff said, “[Manager] and director are very approachable.” Staff were aware of what to do if they felt their concerns were not being listed to by management. One member of staff said, “If I reported a concern to management and they did not do anything I would seek further support from the Care Quality Commission (CQC).

The director told us they had an open door policy and they talk to people, family and staff daily. We observed the director walking around the home on the day of the inspection engaging with people, visitors and staff. We heard the director speaking with a visitor who was having difficulty making arrangements for a taxi to take them home. The director contacted a taxi service for them. People and visitors told us they always see the director and manager walking around the home and spoke positively of their interactions with them. One visitor told us when their relative was moving into the home the director went and collected them because they were having trouble with organising transport. This meant management were aware of the day to day culture in the service and kept this under review by regularly interacting with people, visitors and staff.

There was a clear vision and a set of values that was led by the director of the service. They told us they wanted to a provide a well-managed, caring professional service for people, staff and families. They said they would do this by being approachable, proactive, friendly, listen in a professional manner and provide a homely atmosphere where people could feel safe and calm. Staff confirmed these visions and values and people we spoke with confirmed they felt the service was homely. One person said, “This is my home and I have lived here for a long time.”

The home had a system in place to analyse, identify and learn from incidents, and safeguarding referrals. Members of staff told us they would report concerns to the nurse in charge on shift or the registered manager and follow this up in writing. Incidents and safeguarding referrals had been raised and dealt with. Staff we spoke with knew how to report incidents and raise concerns.

There were quality assurance systems in place which consisted of surveys being given to people and sent to relatives and professionals such as Podiatrist, therapists, community matrons and GP’s**.** Quality questionnaires had been sent to professionals in June 2014 gave positive feedback regarding communications and working relationships between the staff and professionals. One professional’s feedback stated “All people were well looked after and good positive relationships were formed between themselves ,staff and people. We saw this information was shared in meetings with staff and people. People completed ‘resident questionnaires’ which were used to assess the quality of food and attended regular meetings to discuss and make suggestions on any changes within the home.

The director had created a Digital Care System (DCS), which was unique to this home. The DCS ensured people received care when they needed it and assisted them in the prevention of dehydration and developing pressure sores. The director told us that they are considering developing the DCS further so external professionals would be able to confidentially access the information directly when they required it. This meant the service recognised innovation.