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Enter & View

Report

Beechfields Nursing Home

12th September 2019

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Part of the Healthwatch Staffordshire remit is to carry out Enter and View Visits. Healthwatch Staffordshire Authorised Representatives will carry out these visits to health and social care premises to find out how they are being run and make recommendations where there are areas for improvement. The Health and Social Care Act allows Authorised Representatives to observe service delivery and talk to service users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies. Enter and View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation – so we can learn about and share examples of what they do well from the perspective of people who experience the service first hand. Healthwatch Staffordshire Enter and View visits are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit, they are reported in accordance with Healthwatch Staffordshire safeguarding policy, the service manager will be informed and the visit will end. The Local Authority Safeguarding Team will also be informed.

Provider Details

Name: Beechfields Nursing Home

Provider: Beechfields Nursing Home Ltd.

Address: 1 Wissage Road, Lichfield, Staffordshire, WS13 6EJ

Service Type: Nursing Home caring for adults aged over 65

Date of Visit: 12th September 2019

Authorised Representatives

This visit was made by three Authorised Representatives of Healthwatch Staffordshire.

Purpose of Visit

Independent Age, a national charity, have developed a set of 8 Quality Indicators for care homes. We are including an evaluation, based on our findings on the visit, of these quality indicators, which are as follows:

A good care home should…

1. Have strong, visible management
2. Have staff with time and skills to do their jobs
3. Have good knowledge of each individual resident, their needs and how their needs may be changing.
4. Offer a varied programme of activities
5. Offer quality, choice and flexibility around food and mealtimes
6. Ensure residents can regularly see health professionals such as GPs, dentists, opticians or chiropodists
7. Accommodate residents personal, cultural and lifestyle needs
8. Be an open environment where feedback is actively sought and used

The methodology to be used is to;

- Talk to residents about all aspects of their care and whether this is delivered in a way that promotes their dignity and independence including the ability to make choices about their daily lives.
- Talk to residents about staffing levels and whether they feel safe with the level of the care provided.
- Talk to relatives, if they are available to ask if they are happy with the care provided to their relatives and whether they are aware and feel able to report any concerns/ complaints.
- Speak to staff about training, turnover, support staff levels.
- Observe interaction at all levels between residents, staff manager, and visitors.

Physical Environment

External

Beechfields is a mid-20th century property, adapted to its current use and with a large extension at the back.

Signage is limited to a small nameboard on one side of the entrance wall; this gives no indication of the function of the building.

There is surfaced parking space at the front of the property. To one side, a Local Authority commercial refuse collection bin was overflowing, with cardboard on the ground, but the rest of the area appeared tidy. The front gardens, not accessible to residents, looked rather neglected, with many weeds, but the building itself appeared well-maintained.

The main entrance to the building was easily found.

Gardens to the rear, accessible to residents, were enclosed and secure, but looked tired. Some of the furniture and planters appeared in need of renovation. Bird feeders visible from inside were noted.

We were told that a maintenance worker is employed in a dual role, undertaking tasks in both the home and the gardens, with the former having priority.

There is no external CCTV.

Internal

There is a bell to gain entry with a digital numbered door lock. In the entrance area, which is fairly well lit and airy, there is a signing in book and noticeboard. A registration certificate dated 2nd May 2019 was on display near the entrance.

There is no internal CCTV.

The home appeared well decorated throughout and maintained to a good standard. The hard and soft furnishings for residents are modern and appeared comfortable and in good condition.

When taken around the home we found the corridors clean and free of obstacles and clutter.

There are three communal lounges, a dining room, a conservatory, and a garden for resident access.

Access to the first floor was by keycode. Access to the lift was unrestricted, but we were told that residents on the first floor were non-ambulant and unable to access it unaided. A cracked pane of window glass was observed in a first-floor corridor.

The bedrooms appeared adequate in size with some larger than others. Their doors were all painted in plain white with some having very small identity plates at the top, which were not easy to read. We wondered if more variety and bolder identification would be beneficial to the residents. The doors to toilets and the dining room had appropriate pictures on them.

Bedroom doors had guards. Most were open. One resident in bed was observed to have a mattress on the floor next to their bed, rather than a bed rail. We were told that this was because of their having climbed over bed rails, and that the mattress has a sensor mat with an alarm.

The manager has since further explained this to us as follows:

Some residents who have dementia are at risk of falling out of bed. For health & Safety reasons they have bedrails and bumper pads in situ. But if they are at risk of climbing over, they have to have a crash mat instead, this poses less risk than climbing over and falling on to the floor. A crash mat with a sensor mat in place. This is so that if they do roll out of bed, which is a HI LO bed, the sensor mat will alarm and inform staff there is a problem. This is a less restrictive practice and Deprivation of Liberties are always informed of any restrictive practice (Dols). Bed rails and bumpers are always our first option but for safety reasons sometimes a crash mat and sensor mat is inevitable. This information is documented in the care plans and a risk assessment is always completed. This is an appropriate measure following quality monitoring inspections.

Stocks of disposable gloves and aprons were seen. Hand sanitizers were observed at points in the home.

No human odours were detected anywhere in the home.

Resident Numbers

23 of the 35 registered places beds were occupied on the day of our visit.

Staff Numbers

The current staffing complement was tabulated for us as follows:

Nurses: 1 on duty 24 hours a day. Total of 6 posts.

Carers: mornings 7 or 8, afternoons 5, evenings 5, nights 3. Total of 19 posts.

Activity co-ordinator: 1 part time (3 sessions per week)

Domestics: mornings and afternoons 3. Total of 4 posts.

Maintenance: 1 part-time. 2 shifts per week. Also maintains the gardens. Can be called upon additionally if needed.

Administration: 1 post.

Management: mornings 2, afternoons and evenings 1. Total of 3 posts.

Catering: mornings and afternoons 2, evenings 1. Total of 4 posts.

Recruitment of 3 new employees is in progress.

Agency Usage

We were told that one post is currently being covered by agency staff.

When needed, staff are sourced from one of three agencies.

There is one longstanding bank member of staff.

Management

Management – A good care home should have strong visible management.

The manager should be visible within the care home, provide good leadership to staff and have the right experience for the job.

Our findings

We were told that Registered Manager (a qualified nurse), who has in post since June 2018, was on annual leave on the day of our visit. We were shown around the home by and later interviewed the Compliance Officer (Administrator). The home also has a clinical lead nurse.

We were told that the manager (or in her absence the person in charge) has a daily walk around the whole home, with spot checks on residents and their rooms. The nurse in charge at night does the same and the manager does occasional night-time spot checks.

Comments

Beechfields has a variety of senior staff assisting the Registered Manager and contributing to the management of the home.

Staff Experiences and Observations

Quality Indicator 2 – Have the staff the time and skills to do their jobs

Staff should be well-trained, motivated and feel they have the resources to do their job properly.

Our findings

We found all staff to be warm and friendly and observed a relaxed atmosphere in the ground floor lounge areas, with staff undertaking their duties in a timely and unhurried manner. Most of the residents seen were either sleeping or unresponsive in this lounge at this time.

The transfer of a resident to a wheelchair by hoist, for a move into the dining room at lunchtime, was observed. This was done gently and well with the carers talking her through what was happening and what was coming next.

We observed good instances of staff caring for and assisting residents in the dining room.

A domestic working on the first floor reported that she had worked as a care assistant but decided to change roles. She enjoys her work and speaking with residents when the opportunity arises. She told us she prides herself on maintaining high standards of work and cleanliness and that staff related well to each other.

A recently appointed care assistant told us he has just applied to complete his NVQ level 1 training. He seemed very settled and committed in his new role.

The Compliance Officer told us that all staff have a good and close relationship with each other as well as residents simply because of the nature of their work and the current challenges of working with a very high proportion of heavily dependent and/or terminally ill residents.

All the staff spoken to emphasised the importance of training and that they were encouraged by the Manager to apply for NVQ training as soon as they are in a position to do so. The Clinical Lead told us some training is now completed in-house to deliver refresher courses for carer.

It was further explained to us that a variety of training methods and providers are used: manual handling by the Compliance Officer; Acorn training for NVQs (3 and 5; also Care Bundles and Care Certificate); dietitian as appropriate; health and safety by e-learning; induction includes Mental Capacity Act, Deprivation of Liberty Safeguards and safeguarding. Refresher and updated safeguarding training is provided annually to all staff. We were advised that Training companies come into the home to deliver all mandatory training and that home has staff attend external training courses with the CCG (Clinical Commissioning Group) and St.Giles Hospice.

The lead nurse is working towards NVQ level 5 qualification and told us that some staff had gained level NVQ level 2 or 3.

Comments

There appeared to be sufficient staff present on the ground floor to meet the needs of residents, though during observations in the communal rooms there was little in the way of communication between staff and residents, although many were napping at this time. We did note good instances of staff caring for and assisting residents in the dining room.

Quality Indicator 3 – Do staff have good knowledge of each individual resident, their needs and how their needs may be changing

Staff should be familiar with residents' histories and preferences and have processes in place for how to monitor any changes in health and wellbeing.

Our findings

We were told by the lead care worker that the staff team know all residents well and become close to them. As a result, morale tended to be "up and down particularly when a resident passed away". She noted the importance of being 'professional', but it was part of the work to be heavily involved with residents and it was unavoidable that staff would become emotionally involved.

There is a questionnaire for residents and their families to complete to enable a good understanding of a new residents needs and their history.

We were told that all staff know the residents as individuals and can read all the care plans. We were told that every resident has one and that they are up to date. Diets, nutrition and allergies are highlighted.

There is a whiteboard in the nursing office, on which any changes to a resident's needs are written; these are highlighted at shift changeovers.

The Activities Coordinator has a folder with a 'This is me' life history of each resident, supplied by the resident or their family. This is accessible to all staff.

Comments

Our discussions and observation led us to conclude that the staff have a good knowledge of individual residents and their needs.

Activities

Quality Indicator 4 - Activities – Does the home offer a varied programme of activities?

Care homes should provide a wide range of activities (and ensure residents can access these) in the home and support residents to take part in activities outside the home.

Our findings

The Activities Coordinator was not present during our visit but was spoken to by phone. She told us that she has undertaken her current role for 18 months and prior to that she was a care worker at Beechfields. Her enthusiasm for the role was evident.

She starts work at 8.00am three days a week and helps with caring duties and managing residents with their meals until 9.30 am when she begins her own work until 12.00 noon. Again at 2.30 pm until 4.45 pm. She involves residents in bingo, card games, scrabble and other games. She occasionally makes cakes with residents who want to be involved. The residents join in singing and a hairdresser visits on a regular basis. She told us that her time is split between the ground floor and residents on the first floor (we were told by the lead clinical Nurse that over half of the 23 residents are quite poorly or diagnosed as terminally ill). Ponies have been involved in activities with some of the residents.

There is an activities fund administered by the Manager and which currently has a balance of approximately £500. These monies are derived from jumble sales and other money raising activities. If staff or family of residents have a subsidised meal at the home, that money is put toward the Activities Fund.

Other activities mentioned to us during our visit included knitting and making Rice Krispies cakes and pom-poms. We were told that group and individual activities are informed by the resident's 'This is me' life history. For the considerable proportion of bed-fast residents, including those receiving palliative care, individual activities are provided for those can benefit from them.

When the activities coordinator is not present, care and nursing staff provide support, including reading and handholding.

The major annual festivals are marked.

Residents' birthdays are celebrated with banners, cake and singing.

For couples, Valentine's Day is made special.

There are opportunities for outside visits for some of the more mobile residents and we were told that they have visited Lichfield Cathedral in the past. However, the high dependency of most current residents means that there have been no recent group outings, but individuals are taken to local accessible facilities, either on foot or by wheelchair. The nearby Tesco and its Costa coffee shop were mentioned. All residents need to be accompanied.

Some residents can benefit from support with hobbies or interests. One belongs to a book club, and we were told of another who, although no longer able to paint in the way they once did, derives pleasure from 'magic paints', by which an image emerges when wetted.

Comments

While the Activity Coordinator is evidently providing a range of opportunities, we wondered whether the hours she was able to dedicate to the task were sufficient to meet all residents' individual needs.

Catering Services

Quality Indicator 5 - Catering – Does the home offer quality, choice and flexibility around food and mealtimes?

Homes should offer a good range of meal choices and adequate support to help residents who may struggle to eat and drink, including between mealtimes. The social nature of eating should be reflected in how homes organise their dining rooms and accommodate different preferences around mealtimes.

Our findings

The kitchen area appeared to be well organized and clean. The cook and her assistant were friendly and welcoming. There were no adverse findings in the kitchen area.

We were told that menus for main meals rotate every four weeks. The day's menu was seen on a board, with rather faded pictures which did not present an appetising appearance. One had to lean over a table to see the information close-up. We were told that the position of the menu board was under review. There was a choice of cottage pie or omelette for the main course, but no obvious choice of dessert.

A large proportion of current residents have to take their meals in their rooms or in bed. We were advised that a trolley goes round the home mid-morning and mid-afternoon to provide hot drinks to the residents.

The kitchen staff were seen puréeing the lunches for those on a soft diet, the ingredients being those being served for the other residents.

Preparation of residents for lunch was observed; this continuing well after the stated 1.00pm serving time. We saw a staff member taking a meal upstairs to a resident at nearly 2.00pm.

The dining room had adequate seating and tables and was well decorated and clean, but not brightly illuminated. A light fitting was out of order; when asked, a member of staff told us she assumed it was on the list of items for maintenance.

We were told that all residents who are assessed by the nurse in charge as being in need of them, have nutrition and hydration charts. These are kept in the nursing office and are checked and reconciled each night.

Comments

Meals could be improved and with more variety without a major increase in cost. Clearly the arrangements for providing food have been in existence for some time and it appears there has been no effort to improve the imagery or quality of the food. It is to be expected that the resident population may well have limited taste for food; nevertheless, improvements should be considered. We were told these are pending.

Resident Experiences and Observations

Quality Indicator 6 – Does the home ensure that residents can regularly see health professionals such as GPs, dentist, opticians or chiropodists?

Residents should have the same expectation to be able to promptly see a health professional as they would have when living in their own home.

Our findings

During our visit we went to the first floor, we did not notice a member of staff in attendance, although it is possible that staff were attending to residents in their rooms.

Residents can retain their previous GP if their doctor is willing; this was confirmed to us by a resident.

Residents attend a local dental practice when needed.

A local ophthalmologist makes regular visits to the home (providing annual eye tests). This is considered by staff to be a responsive service.

A chiropodist comes to the home fortnightly, seeing half of residents on each visit, so there is four-weekly cycle for each resident. This service is chargeable.

Transport to GP, dentist and optician are chargeable. Transport to hospital is free. Residents are always accompanied on such visits.

The lead care assistant, who was very helpful, told us that some residents can dress themselves and arrange their own personal care. They can also feed themselves and seek drinks regularly, but this group is only a small minority because of their age and degree of mobility.

When we visited, all the residents on the first floor were sleeping or dozing. The Clinical Lead Nurse told us that these residents have their position changed every two hours by staff. We were told that that all residents on the first floor have emergency call bells by their side, but we wondered about their capacity to use these.

On further occasions when we independently visited the first floor, there were no visible signs of staff being present.

The manager has since advised Healthwatch that there is always a member of staff on the floor and that residents are checked on a very regular basis, either by nursing staff or care staff and that staff may not be easily visible if caring for a resident within their private room.

In all bedrooms the television was on and music playing or programmes running; this appeared to be the practice throughout the home.

The manager advised us that this is the residents choice. All the residents are asked for their preference and it is stated in their care plan. There are occasions when it is the family's decision when creating a care plan upon admission - the family may be consulted with because of a resident living with dementia, which applies to some of our residents. There are some residents who choose not to have the TV on and this choice is respected.

Comments

Given the number of very ill residents on the first floor, regular and frequent oversight of their health and condition is important, particularly as we were not sure that some of the residents have the capacity to ring the alarm button to seek assistance when they need it.

Quality Indicator 7 – Does the home accommodate residents personal, cultural and lifestyle needs?

Care homes should be set up to meet residents cultural, religious and lifestyle needs as well as their care needs, and shouldn't make people feel uncomfortable if they are different or do things differently to other residents.

Our findings

Residents' birthdays are celebrated.

We were told that if a resident would like to shop for her own personal things and the weather if fine, they are taken in a wheelchair to the nearby Tesco so that they can purchase personal requirements.

The level of dependency of current residents means that there have been no recent group outings, and none is planned.

We were told that the religious needs of residents are met by the Vicar of St. Michael's parish church in Lichfield, who visits the home on the first Tuesday of each month. We were also that a current resident is a (non-practising) member of the Church of Jesus Christ of Latter-day Saints (Mormon).

We were told that residents have choice over food and drink, and of dress, and that all laundry is done in-house.

Bedtimes are flexible according to the needs and wishes of individual residents. We were told that one resident regularly prefers to stay up until about 1.30am and this wish is respected.

Family and Carer Experiences and Observations

Some residents were asked for their thoughts about living at Beechfield House. One said she "was pleased with her surroundings" but went on say "that some staff can be better than others and more attentive to her needs".

Another resident's family member said that they thought the food was poor.

Quality Indicator 8 – The home should be an open environment where feedback is actively sought and use.

There should be mechanisms in place for residents and relatives to influence what happens in the home, such as a Residents and Relatives Committee or regular meetings. The process for making comments or complaints should be clear and feedback should be welcomed and acted on.

Our findings

We were told that residents' and relatives' meetings have been 'occasional'. They are attended by the owner. One was held in January 2019 and another is planned. The minutes of the most recent meeting could not be found but we were given the typed minutes of the meeting held in August 2018. This was attended by about 18 family representatives. The owner had taken the minutes, which covered a wide range of issues, and were clear and informative.

A quarterly satisfaction survey is conducted. The form is comprehensive, covering all aspects of the home and its operation, and is commendable. We were given the most recent individual return which had been completed by a relative the day before our visit. The respondent was 'very satisfied' with the home's management and administration team, and 'satisfied' with most other aspects of the home and its operation, but only 'fairly satisfied' about food, drinks and snacks; hygiene, grooming and presentation of their relative; the provision of activities; and the home's ability to meet individual needs and preferences.

We were told of two current safeguarding investigations relating to residents: an unexplained foot injury, and a fall resulting in a head injury.

We were told that, on admission, residents and relatives are told how to raise issues or make a complaint, but it was acknowledged that this is not yet in writing 'in the pack'. We were shown the home's photocopied complaints leaflet, which we judged to be of poor quality and layout. It contains some basic information but does not explain the home's procedure in any detail – i.e. what constitutes a comment, representation or complaint, exactly how to make a complaint, or who to approach and how.

When we asked about changes that had been made in response to representations or complaints, we were told that car parking for visitors had been an issue. Staff now park on only one side of the small car park, leaving the other side free for visitors. Action had been taken following a neighbour's complaint that, at night, conversations between staff taking breaks were too clearly audible. We were told that there have been no recent complaints about standards of care or catering.

Comments

While we were told that the Manager has 'an open-door policy' regarding comments or complaints from residents or relatives, we considered that the process and procedure needed to be more visible, and clearly explained and publicised.

Summary, Comments and Further Observations

During our visit there was evidence of good care of residents and of staff working well together.

We visited the first floor on a number of occasions and were concerned that we could not see a member of staff in attendance. We were concerned about the monitoring of the residents on the first floor who were confined to their rooms through illness. We thought consideration should be given as to how the regularity of checks can be ensured as we doubted that some residents would be able to summon help if they needed to.

We were informed that clinicians from the local Medical Centre only visit if, upon telephoning the home, they are told a visit is necessary. We wondered whether regular visits from clinicians would be beneficial considering the fairly high number of quite poorly or terminally ill residents.

As the home is currently in the process of completing a further satisfaction survey, they may be able to use feedback from that survey once the analysis complete to consider any adjustments that may be appropriate.

Recommendations and Follow-Up Action

An improvement in the food display board.

Recognition that some residents and their family think the food on offer is poor or are not completely satisfied.

Review of health care.

Greater oversight of residents who are confined to their rooms with illness with consideration of a nursing station on the first floor.

Provider Feedback

The Manager advised us that the signs on the bedrooms doors were of an approved size for residential homes, but told us that *"We are aware that all rooms should be named - Although I am not dismissing the idea (replacing signs) - it is something that can be looked into".*

"On looking at the menu cards I acknowledge there are 7 out of the 38 cards that are slightly faded. These are what go on the menu board in the dining room. But we do also have a card index to which the residents look at also which is in better condition. We will plan to update the menu photographs to provide a better quality pictorial guide to meals."

"Meals work on a four weekly rotation and are changed frequently. Residents can have something different to what is on the menu and are asked by staff if they want something else. On occasions members of staff have gone over to Tesco to get something for a resident if they want something different and we have not got it in stock."

"I note that one family member said they thought the food was poor. This was not brought to my attention on the lasted survey which is completed tri monthly. I would explain that in the survey, with analysis completed my myself, there are many good comments of family experience and observation – a copy of this is on our notice board near the main entrance."

In relation to checking residents that are confined to their rooms, the Manager told us

"The residents' safety is monitored at all times, the domestic staff are part of our team and would also press the alarm if there was any problems as they are trained to do this"

"I will now consider how to introduce a system to have these regular checks recorded, in order that they can be evidenced if required".

In relation to regular visits from clinicians and end of life care, the Manager told us

"End of life care (EOL) is a discussion we have with the GP, the resident if able and the family. Care homes are regulated by the Care Quality Commission (CQC) Registry, where the Manager of a Nursing Home is a Registered Nurse as are other nursing staff in the home. As a Registered nurse once the resident has been seen by a GP, end of life care is managed by the qualified nursing staff. We have what we call anticipatory medication which is prescribed by the GP and a nurse will make the decision when assessing the resident as to when the medication is administered. This is all done working in the best interest of the resident and as professionals we pride ourselves on giving the best care. Our staff are trained by St Giles hospice in EOL care to ensure we do just that. The training is currently on going."

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