Allington Health Care Limited

Beckfield House Residential Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 17 February 2015 and was unannounced.

The home is a large Victorian house with a modern extension in the village of Heighington near Lincoln. The home is registered to provide care for a maximum of 27 people who need residential care for old age or who are living with dementia. There were 26 people living at the home on the day of our inspection.

There was a registered manager at the service when we inspected. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

The registered manager had completed training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. They were in the process of reviewing people's abilities to make choices about where they lived. The registered manager was aware of the need to refer people who did not have the ability to make a choice to the relevant authority to ensure their human rights were respected.

Staff had received training in how to keep people safe from harm and knew how to report concerns both within the organisation and to external bodies.

Risks when providing care for people had been identified and assessed. However, the registered manager had not reviewed the risks to people of using fixtures on beds to keep people safe.

Medicines were managed safely and checked when coming into and out of the home. Staff took the time to ensure people knew what their medicine was for and allowed them a choice if they wanted to take it or not. Staff made sure people swallowed their medicines before recording it as being taken.

There were enough staff around to ensure people's needs were met. The registered manager spent time on the floor monitoring if staff were able to meet people's needs in a timely fashion and enlarged staffing levels when people's needs increased. Staff received appropriate training and were supported to achieve nationally recognised qualifications. Staff received supervision and appraisals where they could raise concerns and identify training needs

On a daily basis staff supported people to make decisions about the care they received. This included what they wanted to eat. We saw people were supported to maintain a healthy weight and had appropriate referrals to health professionals to ensure they were able to eat safely.

Staff were kind and caring to people. When providing care they talked with people to explain what was happening and why, this enabled people to participate safely in their care. However, we saw the facilities did not always support people to maintain their privacy.

Care given was tailored to people's individual needs and people living at the home and their relatives had been involved in designing their care. However, individual needs were not always recorded in people's care plans. People were supported to take part in activities and maintain hobbies and interests they had before living at the home.

People told us they were happy to raise any concerns with the registered manager. People, their relatives and staff were all confident that the registered manager listened to concerns and took action to resolve the concern.

The provider completed a monthly visit to the home and there was a plan in place to refurbish areas of the home. However, audits were not in place to identify and rectify issues in the quality of care people received.

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?
The service was not consistently safe.

There were enough staff to keep people safe and deliver person centred care. Staff had received training in keeping people safe from harm and knew how to raise concerns.

Most risks to people had been identified and systems in place ensured medicine was administered safely. However, risks around the use of bed furniture such as grab handles and bed rails had not been assessed.

Requires Improvement

Is the service effective?
The service was effective.

Staff received appropriate training and support to provide safe care and people's abilities to make decisions were assessed and respected.

Appropriate advice was sought from health professionals to ensure people were eating safely and had access to prescribed supplements to maintain a healthy weight. People were supported to make choices about their meals and where they ate them, tables were set nicely and people were encouraged to be independent.

Good

Is the service caring?
The service was not consistently caring.

Staff were kind and courteous to people and had a good awareness of people's care needs. However, people's privacy was not always maintained.

People were supported to make everyday decisions about their care and staff involved people in their care by explaining what was happening.

Requires Improvement

Is the service responsive?
The service was responsive.

Care was person centred and met people's individual needs. People and relatives had been involved in planning the care they needed.

People were happy to raise concerns with the registered manager and were confident that they would resolve any issues raised.

Good

Is the service well-led?
The service was not consistently well led.

The registered manager had developed a culture where people living at the home, their relatives and staff all felt confident in voicing their views of the home and improvements which could be raised.

Requires Improvement

Summary of findings

While the provider completed a monthly review of the home and had a plan in place to develop the home, audits around specific areas such as infection control had not been completed.

Beckfield House Residential Home

Detailed findings

Background to this inspection

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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 17 February 2015 and was unannounced.

The Inspection team consisted of an inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care home.

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 home, what the home does well and improvements they plan to make. We used this information and other information we held about the provider to plan the inspection.

As part of the inspection we spoke with nine people who lived at the home. We also spoke with six relatives and a healthcare professional who visited during the inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the registered manager, a senior care worker, a care worker and the cook. We looked at the care plans for three people and their medicine administration records, we also looked at the paperwork relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

All of the nine people we spoke with said that they felt safe living at the home. One person said, "I feel confident, happy and safe here. They are a good staff group."

Staff told us and records confirmed they had received training in how to keep people safe from harm. Staff were clear on how to raise concerns and if they were not satisfied with the action taken, they knew how to escalate concerns both to the provider and to external monitoring organisations. The safeguarding policy was available for staff to access in the office.

Most risks to people had been identified and appropriate assessments had been completed. For example, where people were at risk of receiving pressure ulcers appropriate equipment was in place and people were assisted to use the equipment by staff. However, this information had not been consistently recorded in the people's care plans. In addition, information we held showed a person had become trapped between a grab rail and their bed earlier in the year. The grab rail was a fitting on the bed to give people something to hold on to when getting up. There were no risk assessments on the use of grab rails or bed rails this meant there was a risk a similar incident could occur in the future.

There were plans in place to respond to emergencies. People's mobility had been assessed in case of a fire and their level of risk identified near to their room so that emergency personnel would have immediate access to the information in an emergency. There was also a bag at the front door which contained information that would be needed in an emergency. Access to the home was controlled using a secure entry system and a member of staff met visitors at the door and checked their identity before allowing them access to the home.

The registered manager told us they did not use a tool to calculate required staffing levels, but did monitor workload and how quickly staff responded to requests for support. They told us if staff struggled to meet people's needs and complete tasks they would put another member of staff on duty. All the people we spoke with told us that staff were responsive to the call bells and came as soon as they could depending on how busy they were. We saw that staff responded to call bells and requests for help in a timely manner. The registered manager had completed appropriate checks completed before people to ensure they were suitable to work with the people living at the home.

Medicines were stored safely and systems were in place to ensure the risks of medication errors were reduced. Medicines were accounted for when they were received into the home and when they were disposed, with a reason for the disposal. A person told us, "The [registered manager] makes sure you swallow your pills, otherwise they are very easily lost. She is very efficient." Records showed when people consistently refused their medicines this was followed up with the GP.

We saw the senior care worker who completed the medication round dispensed one person's medicine at a time. They ensured people took all their medicine before recording that it had been taken. While medicine administration was safe we saw the senior carer took people's medicines to them on a tray and would have been unable to quickly secure the medicine in an emergency.

We looked at the medicines administration record charts and could see most medicines had been recorded appropriately. However, where medicine was prescribed to be taken 'as required' records had not been accurately completed to show when and why medicine had been taken. This meant we could not be sure if PRN had been offered appropriately and for the reasons it had been prescribed.

Good

Is the service effective?

Our findings

Staff told us they received a good induction when they started in their new post. This included an introduction to the people who lived at the home and being shown around the building. In addition, staff were trained on all equipment used and a more experienced member of staff monitored them to ensure they were capable of giving an acceptable level of care. The registered manager told us if staff failed to reach acceptable standards they were not employed once their probationary period came to an end. This ensured that staff were fully trained and had the skills to meet the needs of the people they supported.

The registered manager told us and records showed that there was a programme of refresher training which staff were required to complete on a yearly basis. Staff also told us they were supported to work towards nationally recognised qualifications in care.

Staff told us and records showed that they received support from their line managers through yearly appraisals and routine supervisions. Supervisions are meetings between the line manager and member of staff to discuss any concerns or issues the staff member may have. Staff were also supported with monthly team meetings.

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) are laws which protect people's human rights when they are no longer able to make decisions for themselves. The registered manager had attended training on the MCA and DoLS the week before our inspection. They were aware of the need to assess people's ability to make decisions and to refer people who were unable to make the decision they wanted to live at the home to the DoLS authorising authority. They had plans in place to complete assessments on the people living at the home.

Where people were unable to make decisions about the care they received, information on how to make decisions and who to include in decision making process were recorded in people's care plans.

Staff had received training in MCA and in-house training about supporting people to make decisions. For example, one person was confused about whether they wanted to take their medicines. The senior care worker spent time talking to the person explained the medicine and what they were for, assuring them the doctor wanted them to take the tablets. However, they left the person to make their own decision on whether to take the medicine or not.

People said they were happy with the meals. One person said, "You can't fault the food, it's just like home." They added, "There's always plenty of it, and seconds if you want it. It's always home cooked." People had access to drinks throughout the day and people told us they could have a snack whenever they wished.

The registered manager monitored people's weight and when people were unable to maintain a healthy weight they were referred to appropriate health professionals. Where necessary people were supported to take high calorie supplements prescribed by the GP. The cook had also received training on how to use the high calorie supplements in food to support people to maintain a healthy weight.

There was one main meal a day offered at lunchtime. However, people told us and staff confirmed that alternatives were offered if they person did not like the planned meal. In addition, records showed people's likes and dislikes were recorded in their care plan and in the kitchen for the cook to refer to. Where people had difficulty swallowing appropriate assessments had been completed by health care professionals. For example, one person required a soft diet and had their food pureed so they could eat it safely. However, we saw that the food was liquidised together, this meant the person was unable to choose what food they were eating.

A relative said that they knew the GP had visited their mother when needed and that the community nurse came to the home if and when required. Records showed people had access to a range of healthcare professionals including GP's and opticians. A visiting health professional told us they had no concerns about people living at the home and felt that care was good. They said that the staff referred people to them appropriately. They told us they had a message book where they could write down information so staff would know what people's needs were. They said that staff worked with them to assess and monitor people's needs, for example, when continence assessments were needed.

Requires Improvement

Is the service caring?

Our findings

Staff were attentive to people and ensured they were supported and safe. For example, a care worker noticed a person's slipper had fallen off and put it back on for them. The care worker talked with the person telling them what they was doing and giving instructions in an appropriate manner. During the day we observed many such positive and caring interactions. We saw two members of staff assisted a person from their wheelchair into a chair in the sitting room. They used appropriate equipment and were kind and courteous. They gave simple instructions which the person was able to follow to enable them to transfer safely. This ensured people were fully involved in their care and were able to say if they had any concerns about the process.

However, we also observed when staff spoke to each other they were not always aware they could be overheard and their comments could impact on people receiving care. For example, we heard two members of staff making negative comments about the quality of wine people had been offered for lunch. This was done where people could hear what the staff said and may have impacted on people's enjoyment of the wine.

People were encouraged to be comfortable and supported to dress how they wanted. We saw that one person had cuts in the top of their socks. We raised this with the registered manager as they looked uncared for. However, the registered manager explained that the person liked to cut the top of their socks so they were not too tight on their legs. The registered manager told they had offered alternatives but this was what the person chose to do and so staff supported them to feel comfortable.

We saw the lunchtime experience was pleasant and relaxed for people. People were supported to sit in friendship groups and the tables had been set with tablecloths, place mats and condiments. Staff asked people if they wanted to wear protective aprons to keep their clothes clean and respected people's wishes. Where people needed adaptive plates to support their independence, plain white crockery was used which looked the same as all the other plates. This meant people's dignity was maintained as other people would not be aware their ability to be independent was decreasing.

Where people needed support to eat this was given to them in a way which enabled them to enjoy their meals as they would have done before needing support. For example, staff explained what the food was and asked people what they would like to eat for each mouthful. We saw staff gave the minimum amount of support people needed to help people maintain their dignity and encouraged them to be independent wherever possible.

People told us they were able to eat their meals wherever they wanted. However, we saw most people chose to eat in the dining room and this meant the dining room was crowded. The lack of space in the dining room impacted on staff's ability to care for people effectively. For example, there was no room for staff to sit with people who needed supporting with their meals and one member of staff had to kneel on the floor. People were supported to leave the dining room whenever they wanted. For example, we saw one person did not want a pudding and asked to leave after they had eaten main course. Staff helped them to leave.

People who chose to sleep in a bedroom they shared with another person were supported to maintain their privacy with a curtain. This allowed staff to give care without the other person being able to see. People also told us staff respected their privacy. A person said, "The staff always knock before entering my room, they are polite."

While we saw people's dignity was mostly maintained we saw the toilet facilities near the dining room did not allow people to maintain their dignity or privacy. We heard two people shouting for assistance while using these toilets. The bathroom door was open and the individual toilet doors were wide open too. This left people using the toilet exposed to whoever went in the bathroom. We asked a member of staff to help these people and they did so immediately.

Good

Is the service responsive?

Our findings

Staff told us they would review people's care plans by sitting with the person, or if they were unable to contribute to the review, by sitting with their relatives to discuss their care needs. People living at the home and relatives told us they had been involved in planning the care they needed. One relative said, "I know about her care plan and my sister has now put up a list of reminders of things to do for mum on the wall because we were having a few issues. This list acts as a gentle reminder for all the staff, so nothing gets forgotten." Another relative said, "We visit two or three times weekly. We are aware of her care plan it's very thorough and it gets updated."

Care plans we looked at contained information to enable staff to meet people's needs safely and had been update when people's needs had changed. People living at the home told us that staff understood their needs and felt they cared for them well. We also observed that the care delivered to people was tailored to meet their needs. For example, a relative said, "The staff are trained in dementia behaviour which was important to my family. My dad can be feisty especially regarding his food and they just adjust things to meet his needs and mood." Where people displayed behaviour which may be challenging to others, this was recorded in their care plan along with guidance for staff on how to manage the behaviour and ensure people were safe.

There was a good handover of information when the shift changed. We saw information about changes in people's care, GP visits and hospital appointments were discussed so that the staff were aware if people's needs had changed.

People living at the home were supported to maintain contact and links with their families and the local community. For example, one person told us how staff helped them to use the computer to video call their family. People were also supported to access events taking place in the community such as musical nights. There were a range of activities on offer and people were supported to arrange activities to suit their needs. For example, although the local Methodist church visited once a month to lead people in hymn singing, people living at the home had asked for a Church of England service. This had now been arranged for twice a month.

Planned activities included entertainers visiting the home, a person selling old fashioned sweets and bingo. There was a schedule of activities for people to refer to on the notice board. In addition to the planned activities offered people were supported to maintain their hobbies and interests. The library visited the home on a regular basis and people told us they were supported with materials and equipment. For example, we saw one person was busy completing a jigsaw, while another person said, "I am a knitter and they help me if I get stuck, and get me wool and that."

People said they felt confident they could complain if they were not happy and would go to the registered manager. A relative said, "Any worries we or [name] has are taken seriously and acted upon." We saw there was information on how to make a complaint available on the notice board and we saw the provider had responded appropriately to the one complaint they had received since our last visit.

Requires Improvement

Is the service well-led?

Our findings

People told us they were happy with the quality of care provided. One person told us, "I trust them [staff] implicitly and feel completely confident and happy. I don't think there's anything I would improve." However, we found that the provider was not monitoring the quality of service provided to people to ensure that the care provided and the environment continued to meet people's needs.

The provider visited the home on a monthly basis to review the care provided and we saw there was an ongoing programme of refurbishment. However, there was no schedule of audits in place to monitor the quality of service provided and we identified some concerns which needed attention. For example, there was a toilet seat which could not be cleaned properly because the varnish had worn away. This was an infection control risk.

We also found that while the care people received met their needs, this information was not fully recorded in their care plans. The provider did not audit care plans to ensure they reflected the standard of care being given and information about how care could be personalised to meet individual needs was missing. This meant new staff would not get all the information needed to provide care for people from their care plans.

The provider had recently employed an external company to review and update their policies and procedures to ensure they reflected the latest guidance and laws. However, we saw this work was not complete and so there were gaps in the paperwork needed to support a quality service. For example, there was no policy around the mental capacity act.

The registered manager had developed an open and caring environment for people and staff and we saw they spent time on the floor monitoring the quality of care provided. Staff told us the registered manager was happy to have issues raised by staff of any level and they would listen to the concern and try to resolve the issue. As well as staff being able to raise concerns directly with the registered manager, they were supported by team meetings where concerns could be escalated formally through their line manager. In addition, we saw there was a suggestion and complaints box in the entrance hall which people living at the home and staff could use to raise concerns anonymously.

In addition, the provider had completed a quality assurance survey in January 2015. At the time of our visit they were in the process of reviewing the survey results to identify if any actions were needed.

People were able to identify which staff supported them. We saw that staff all wore name badges and there was a picture board in the hallway entrance to the home displaying photographs of the staff and their job role. This meant people and their relatives were aware of who was caring for them and the role each member of staff would perform.

People living at the home took an active part in the resident's meeting and made suggestions and were consulted about changes to the home. For example, one of the lounge areas had recently been redecorated and people living at the home had chosen the new carpets and curtains.

Furthermore, comments made by people were acted on. The registered manager had responded when people living at the home had requested she wore a name badge. The registered manager had asked people their views on the style of the badge and people had chosen a plain badge with big writing so the name was clear to them.