Oldfield Residential Care Ltd

Beech Dene Residential Care 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?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We inspected Beech Dene Residential Care Home on 26 and 27 August 2015. The service is a residential care home which is registered to provide accommodation to older people who require personal care and who may have a physical illness or are living with dementia. At the time of our inspection, 35 people used the service. At the last inspection of the service on 10 September 2014, the provider was compliant against the regulations we inspected against.

The service had a registered manager. 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 and associated Regulations about how the service is run.

Summary of findings

People did not always have risk assessments and management plans in place to guide staff on how care should be provided or updated when their needs changed.

People were not always protected from harm because equipment meant to support people with their moving and handling was not always used safely.

People told us that staff did not always have time to sit and interact with them. Staff did not always ensure that people's dignity was maintained at all times.

The provider did not have effective systems in place for regularly assessing and monitoring the quality of the service provided. People's care records did not always reflect the care they received. This meant that people were at risk of receiving inappropriate care that did not meet their needs. There were no systems in place for ensuring that required actions following audits were implemented.

There were not always enough staff on duty to meet people's needs. The provider did not have effective systems in place for assessing and monitoring staffing levels to ensure that people's individual needs were met safely.

The provider did not consistently follow the guidelines of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure that people were not being unlawfully restricted of their liberty. Staff did not always have a good understanding of the relevant requirements MCA and DoLS. The MCA and the DoLS set out the requirements that ensure where appropriate; decisions are made in people's best interest when they are unable to do this for themselves.

The design and adaptations within the home were not always suitable for people who lived with dementia.

People were not always supported to engage in activities they enjoyed. We observed people sitting for long periods without meaningful activities.

People told us they felt safe and protected from harm. Staff understood what constituted abuse and knew what actions to take if abuse was suspected.

People told us they liked the food and were supported to eat and drink adequate amounts. People were offered a choice during meals. People were supported to attend healthcare appointments and staff liaised with their GP and other healthcare professionals as required in order for people's health and social care needs to be met.

People told us and we observed that staff were kind and respectful. People told us that the provider responded to their concerns appropriately. There were systems in place to deal with complaints and concerns.

People who used the service, their relatives and the staff were very complimentary about the registered manager. They told us the registered manager was always available and was approachable. We observed that they had a hands-on management style. People and their relatives told us they provided feedback about services on a regular basis.

We identified that the provider was not meeting some of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 we inspect against and improvements were required. You can see what action we have told the provider to take at the back of the full version of the report.

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 always safe.

People did not always have risk assessments and management plans in place to guide staff of how their care should be provided. There were not always adequate numbers of staff on duty to meet people's needs. People medicines were not always stored safely. People told us they felt safe that the service. Staff understood what abuse was and knew what actions to take to safeguard people from harm.

Requires improvement

Is the service effective?
The service was not always effective.

Staff did not always have a good understanding of the MCA and DoLS requirements. The environment of the home was not always suitable for people who lived with dementia. People were supported to eat and drink adequate amounts. People had access to other health professionals to ensure that their health and wellbeing was maintained.

Requires improvement

Is the service caring?
The service was caring.

People's dignity was not always maintained. People told us and we saw that care was sometimes rushed. People told us and we saw staff demonstrated kindness and compassion when they provided care. Staff knew people's needs and provided care in line with people's preferences and wishes.

Requires improvement

Is the service responsive?
The service was responsive.

People were left for long periods without meaningful activities which they enjoyed to prevent boredom. People were not always supported to go out in the community or garden areas. The provider had systems in place for dealing with complaints.

Requires improvement

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

The provider did not have effective systems in place to regularly assess and monitor the quality of the service provided. The provider did not always ensure that people's care records reflected the care they received. The registered manager was approachable and supported staff to carry on their roles effectively.

Requires improvement

Beech Dene Residential Care 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 was 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.

This inspection took place on 26 and 27 August 2015 and was unannounced. The inspection was undertaken by one inspector, an expert by experience who had experience in caring for a person who lives with dementia and a specialist advisor with specialist knowledge in moving and handling techniques and equipment and in training staff.

We reviewed the information we held about the service. Providers are required to notify us about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We refer to these as notifications. The provider notified us of incidents which had occurred at the service. We reviewed additional information we had requested from the local authority safeguarding team and local commissioners of the service.

We observed how care was provided and carried out and observed how people were supported to eat and drink. This helped us understand people's experiences of care.

We spoke with 14 people who used the service, two relatives, six care staff members, the deputy manager and the registered manager. We also spoke with one healthcare professional who visited the service on the day.

We looked at seven people's care records to help us identify if people received planned care and reviewed records relating to the management of the service. These included audits, health and safety checks, staff files, staff rotas, incident, accident and complaints records and minutes of meetings. These records helped us understand how the provider responded and acted on issues related to the care and welfare of people, and monitored the quality of the service.

Requires improvement

Is the service safe?

Our findings

People who required assistive technology for moving and handling were at risk of unsafe and inconsistent care due to inappropriate risk assessments and lack of guidance as to the type of assistive technology they required for their moving and handling. For example, we saw that chair and bed raisers had been applied for one person who was totally dependent on two staff to be transferred and also required use of assistive technology for moving and handling. A staff member told us the person had fallen out of bed several times and continued to be at risk of falling. The staff member said, "We can't get a profile bed, so we have raisers on the bed because the staff get back ache when assisting this person to dress." We checked the person's care records for risk assessment and plans for the use of bed raisers but there were none and the person's safety had been compromised.

We observed two staff members moving a person with the use of assistive technology. We noted that the staff members not used safe and appropriate methods to ensure that that person's head was moved safely and protected from harm whilst they were being hoisted. We also noted that the staff were not aware that part of the assistive equipment was about to trap the person's finger when the part was descending. We had to stop the manoeuvre for the person's own safety. This showed that staff did not always managed equipment safely in order ensure people's safety.

The concerns above showed that there was a breach of Regulation 12 of the Health and Social Care Act 2008 Regulations 2014.

Staff told us there were not enough staff on some days to meet people's individual needs. A staff member commented, "It can be difficult when more than one person wants to go to the toilet", however, they said they worked together well as a team to ensure that people received the care they required. We observed people sitting for long hours without engagement from staff or sleeping in the chairs during the morning period. Staff told us this was because the person responsible for activities was engaged in activities with people on a one to one bases and the day was a scheduled "pamper day".

The registered manager told us that staffing levels were determined at the head office by the operations manager; however they could increase staffing level whenever the needs arose. We saw that people's dependency levels were assessed regularly; however, it was not used to determine staffing level and ensure flexibility in staffing numbers when people's needs changed or when more than one staff was required to provide care to a person. The provider had not ensured that staffing numbers were appropriate to ensure that people were not left unattended for long hours when days were set aside for one-to one activities.

All the people we spoke with told us they felt safe and protected from harm. The relatives and the professional we spoke to told us they felt the service was safe and that any concerns would be reported and dealt with appropriately. Staff we spoke with knew what safeguarding was, how to identify abuse and what actions to take if they suspected abuse. They told us they would report any abuse to the registered manager in the first instance and were confident that the abuse would be reported and dealt with appropriately. The registered manager showed us records of how they had dealt with a recent allegation of abuse. They said, "I wouldn't stand for anyone being abused. I will report the abuse immediately and do an internal investigation too".

Staff told us and we saw that recruitment checks were in place to ensure people were suitable to work in the service. We saw staff had Disclosure and Barring Service (DBS) checks in place. The DBS is a national agency that keeps records of criminal convictions.

Requires improvement

Is the service effective?

Our findings

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA and the DoLS set out the requirements that ensure where applicable, decisions are made in people's best interests when they are unable to do this for themselves. Some of the people who used the service had told us they were not allowed to go out into the gardens. Staff told us, and the people's MCA assessments showed that they were not always able to make certain decisions about their care and safety. We found that DoLS referrals had been made for these people; however staff did not have a good understanding of the principles. A staff member said "MCA is when someone can't do things for themselves" and another staff member said, "If they [person who used the service] don't understand why they are in the home, we would ask for a DoLS authorisation". Staff told us they had received recent training; however, staff we spoke with did not demonstrate a good understanding of the MCA (2005).

The provider did not always make reasonable adjustments in the environment to support people who lived with dementia. People who used the service expressed the wish to access the garden and outside surrounding, but staff told us that people had to be accompanied in the garden because access to the garden was not very safe. A staff member commented "It's an old building and there are parts of it that could be done up. The garden doesn't get used really. It's mainly indoor activities". The registered manager told us that there were plans in place to make the outside environment of the home and the garden more accessible and safe for use by people who lived with dementia.

People who used the service and relatives told us that they felt that the staff understood their needs and had the skills to provide them with care and support. People had key workers responsible for their care. This was to ensure consistency in how people's care was managed and provided. We asked specific questions about people's care needs and what staff told us reflected what we say in people's records. A newly recruited staff member told us they that they thought their induction was 'good' and had prepared them to meet people's needs. They told us they worked under supervision for a period of time until they assessed as competent enough to work independently. A professional we spoke with told us staff always provided them with relevant information relating to people's care and treatment. They told us that the staff knew the people who used the service well.

All the people we spoke with told us they liked the food. One person said, "Food is marvellous". The staff come round with a small menu". During meals, we observed that people were offered a choice. One person said, "Someone comes round and asks us what we would like to have, they have different things each day". There were picture menus to help people make a choice as to what they wished to eat and to remind them of what was on offer. People told us and we saw that drinks were available and served throughout the day. We saw that people were encouraged to eat independently, but support was offered to people when required. We noted that the atmosphere was pleasurable during meals. People's weights were monitored regularly and records showed professionals were contacted when there were concerns about people's weight or if people's eating and drinking had declined.

People were supported to maintain good health. We saw that people's health care needs were assessed and monitored. We saw that when people's needs changed staff noted this and made referrals to relevant health care professionals. We saw that professionals visited the home to review people's care. A professional we spoke with told us that the home maintained good contact with them and they were always notified when there were concerns about people's health and wellbeing.

Requires improvement

Is the service caring?

Our findings

Most of the people we spoke with commented that staff were "always busy" and "don't have much time to spend with us." One person who used the service said "If there is a genuine problem, you can ask them." Another said "You have to speak up." Staff we spoke with told us that they were sometimes very busy and did not often spend as much time with people as they would like to. A staff member commented, "It feels rushed sometimes as it can be a bit of a juggle sometimes". We observed that care was rushed sometimes and staff appeared not to have the time to sit and talk with people. We observed full cold cups of tea from the morning coffee being cleared away from people who were unable to help themselves to the drink.

We observed that staff did not always ensure that people's dignity was maintained when care was provided. We observed one person who used the service being hoisted into a chair. The person was not covered during the procedure and so their legs and other body parts were exposed. The person told us they did not mind being hoisted uncovered, however we were concerned because the person was not wearing any under garments and their body had been exposed. We brought this to the attention of the registered manager who told us they person did not like to be covered up when they were being hoisted and preferred not to wear undergarments. However the arrangement had not been made to ensure that the person was hoisted in a manner that minimised exposure of their body and maintain their dignity.

One person who lived with dementia and could not communicate had been sitting on a pressure relieving cushion all morning. Their care plan had identified the need to minimise the risk of pressure sores by supporting the person to lie in bed at certain periods of the day so as to relieve pressure from their buttocks. We brought it to the attention of a staff member after lunch that the person had been sitting on their chair all morning and the staff member told us they had to go for hand over. The person was left sitting on a toilet sling for a further 35 minutes before staff came to assist them into their bed for a rest. The person's comfort and dignity had not been maintained.

The concerns above showed that there was a breach of Regulation 10 of the Health and Social Care Act 2008 Regulations 2014.

People and their relatives were involved in making decisions about their care. People told us that staff always obtained their views about how they wished to receive care and provided care in line with these. We saw staff seeking the views from relatives about the care of their relatives who lived at the home. People's records showed that staff had spent time with them to obtain their views about their care and how they wish to receive care and support. We saw that people were supported to have advocates to support them in expressing their views when they were unable to do this for themselves.

People told us that staff were nice and treated them kindly and we observed this. All the people we spoke with commented on the kind and caring nature of the staff. They used words such as described them as "caring and kind", "excellent" and "lovely," to describe staff. One person who used the service said "they are very nice. They don't brush you away." A relative said "they are kind. Some of them bend over backwards for you." We saw people were hugged by staff when they came to them for reassurance or support.

Requires improvement

Is the service responsive?

Our findings

People told us and we observed that they were not always able to engage in activities of their choice, when they wished to. Some people told us they felt bored due to lack of activities they enjoyed and some people told us they wished to be able sit out in the garden but were not always able to do so. One resident said “There is no one to take you out”. Another person said “We don’t go out in the garden. There is something wrong with the garden. There is no going out unless you ask. We used to be able to do but not now”. A relative commented “I can’t understand why we can’t use the garden”. One person commented, “There is not a lot to do.”

Staff we spoke with told us that people were not engaged in activities because the day was planned for one-to-one activities with activities people. We saw that the activities person was engaged in one-to-one manicure session with female service users. We noted that during the morning and the first part of the afternoon a number of people who used the service were sitting in the same chair in one of the lounges with nothing to do or to look at. This showed that the provider had not taken in to consideration other ways of keeping people engaged in activities they enjoyed, when the activities person was engaged in one-to-one activities with people who used the service.

People told us that a variety of activities took place within the home which people told us they enjoyed. They were very commendable of the staff member responsible for activities. One person said, “The activities lady is person in very kind. They do Bingo and Dominoes with me”, another person said, “I enjoy the sports activities” and another person told us that staff sometimes took them out to the local shop and for walks in the local park. There was an activities time table which provided information of activities that took place daily and the activities person maintained a record of activities they had engaged people in.

People were supported to maintain their religious beliefs. People told us that church services were held in the home and on a regular basis a vicar visited to give communion to residents who wished to receive it.

People who used the service told us they would approach staff if they had any concerns and they felt that they concerns would be dealt with appropriately. They told us they had not had any reason to complain about the service they received. The registered manager told us they had not received any formal complaints about the service; however they ensured that concerns were dealt with as quickly as possible. We saw that they had a system in place to deal and respond to complaints

Requires improvement

Is the service well-led?

Our findings

We found that care records did not always indicate the type of assistive technology people required for moving and handling. We saw two staff members transferring one person with the use of a sling meant for toileting rather than a sling meant for chair to chair transfers. We reviewed the care of three people who needed assistance from staff and assistive technology to be transferred from one place to another and saw that their moving and handling risk assessments were not consistent and did not provide clear guidance to staff with regards to the identification of the hoist and sling type, size and loop colours for each of the resident. This meant that the care records did not give clear guidelines to existing and new staff on how people who required assistive technology for moving and handling could be moved safely.

A staff member told us that one person who needed support from staff with their moving had "Good and bad days with mobility". They said, "One day they would stand and the other they wouldn't". However, we saw that there were no risk assessments or plans in the person's care records to guide staff on how the person should receive consistent care when they needed support.

We saw that care records did not always indicate that people who had been prescribed topical creams due to the risk of them developing pressure sores were receiving the creams. We also found staff did not consistently record the total daily fluid intake for people who were at risk of dehydration. This meant that staff could not always be assured that these people had received their daily required fluid intake in order to remain well.

The provider did not have effective systems in place to ensure that people's care records were reviewed and updated to ensure consistency in care provision and to reflect people's current care needs. For example, some sections of one person's care records stated that they had to be given a pureed diet because they were at risk of choking. However, another section of the person's record stated that they were to have a fork-mashed diet. We observed staff supporting the person to have fork mashed. This showed that the person's care records did not reflect the care they received. Another person who "required their portions increased and extra cream placed in their meals" as directed by a health professional in order to prevent further weight loss, did not have a care plan in place to guide staff on how they would ensure that the recommendations made were followed consistently.

The systems in place to assess monitor and improve the quality and safety of the services provided the quality of the service provided were not effective. The registered manager told us that they and the deputy carried out a monthly audit of care records and the seniors were responsible for reviewing and updating people's care records. However care record audits carried out by the provider had not identified the concerns we found with care records. There were also no systems in place for ensuring that concerns identified from the audits were monitored and acted on.

The provider had not identified that the fridge temperature was not being monitored regularly to ensure that medicines stored in the fridge were safe for use. We saw that people's insulin was stored in the fridge however; we noted that during a given period the fridge temperature had not been monitored for over 12 days. The deputy manager told us they carried out monthly medicines audits; however they had not recognised that fridge temperature audits were not carried out regularly. We brought this to the attention of a staff member who said, "It should be done daily. It's been mentioned in staff meetings. The senior on duty does the temperatures".

The concerns above showed that there was a breach of Regulation 17 of the Health and Social Care Act 2008 Regulations 2014.

People we spoke with knew who the registered manager was and told us that the registered manager was friendly and approachable. One person who used the service said, "I know her, she's very nice". Staff we spoke with were complementary of the registered manager and the deputy. One staff member said". The manager and deputy are out on the floor a lot of the time. Problems do get dealt with immediately. I feel we all work well together and as a team and do our best to make sure the residents are safe and happy". Another staff member said, "The manager is always available and they are very approachable". The registered manager said, "I am out there and I know what is going on". We saw that the registered manager and the deputy had a

Requires improvement

Is the service well-led?

good rapport with the people who used the service and staff. We observed that they spent time talking with people and people could got to the office at any time to speak with them if they had any concerns.

Staff told us they had regular supervision and staff meetings. A staff member said, “We discuss any issues we might have and the manager brings up things we need to know and achieve and we discuss how we’re going to do that”. We saw records that demonstrated that staff received regular supervision and meeting of staff meetings that showed that key issues around care provision were discussed and actions put in place. This showed that the provider promoted an open and inclusive culture within the service.

The provider submitted notifications such as notifications relating to the death and injuries of people who used the service. It is a registration requirement for providers to notify us of such events. Other conditions for the provider’s registration with us were being met.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. People did not always have appropriate risk assessments and management plans in place to guide staff on how they should receive care safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not always treated with dignity and respect. People told us that staff did not always time to listen to them. Care provisions was rushed sometimes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not always ensure that records relating to the care and treatment of people who used the service were accurate, up-to-date and consistent. The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the services provided the.