St. Cloud Care Limited

# The Boynes Care Centre

## Inspection report

Upper Hook Road
Upton-upon-Severn
Worcester
Worcestershire
WR8 0SB

Tel: 01684594001
Website: www.stcloudcare.co.uk

Date of inspection visit:
18 May 2016
24 May 2016

Date of publication:
02 September 2016

## 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? | Good |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

At our last inspection on 27 and 28 April 2015 we asked the provider to take action to make improvements in how people received person centred care and this action has been completed. The service was rated as "Requires Improvement" overall.

At this inspection, we could not be assured that the necessary improvements to other areas of people's care had been made. You can see what action we told the provider to take at the back of the full version of the report.

This inspection took place on 18 and 24 May 2016 and was unannounced.

The home provides accommodation for a maximum of 40 people requiring nursing and personal care. There were 23 people living at the home when we visited. A registered manager was in post when we inspected the service. 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.

People's medicines were not always stored appropriately and concerns about how the medicines were stored were not shared with the registered manager. This meant that people may have taken medicines that were not stored as they should have been and the medicines may have been affected.

People were supported when they needed help in communal areas where there was likely to be a staff member around. Staff offered help and support to be people when they were in the lounge or dining areas.

People were supported by staff that received training and support from their line manager. This gave staff opportunities to discuss issues of importance to them and discuss people's care if needed.

Staff supporting people did not always know which people were subject to a Deprivation of Liberty and how they were affected. This meant that we could not be assured that people were not unlawfully restricted when they were being cared for.

People were not always offered choices throughout their meal and were allocated a pudding based on their ability to eat. People's mealtime experiences were affected by staff that did not always engage with them or who spoke about them to other staff in their presence.

People were not always cared for in a manner that demonstrated dignity and respect. Staff were at times task focussed and did not empathise with the person they were supporting. This caused some people unnecessary distress. Staff did not always engage and support people in a manner that showed a caring

attitude as people were categorised as either having "Dementia" or "MS".

People's care was updated based on people's changing medical needs. People's individual interests were being supported although people who had specific needs about their care did not get an opportunity to discuss these.

People understood they how they could complain if they needed. Where people had raised a formal or informal complaint they were satisfied that action had been taken. A process was in place for acknowledging and responding to complaints.

People did not always benefit from care that was high quality because systems in the home for ensuring people received this were ineffective. The registered manager did not have a team that understood or delivered care to people, that was high quality, regardless of where they lived within the home.

Staff supporting people did not ensure issues affecting people's care were brought to the attention of the registered manager so that action could be taken. The registered manager's system for ensuring staff demonstrated caring with dignity and respect was not effective. Although staff was behaviour was being monitored, staff did not consistently demonstrate a caring attitude throughout the home.

People understood they how they could complain if they needed. Where people had raised a formal or informal complaint they were satisfied that action had been taken. A process was in place for acknowledging and responding to complaints.

People did not always benefit from care that was high quality because systems in the home for ensuring people received this were ineffective. The registered manager did not have a team that understood or delivered care to people, that was high quality, regardless of where they lived within the home.

Staff supporting people did not ensure issues affecting people's care were brought to the attention of the registered manager so that action could be taken. The registered manager's system for ensuring staff were safe to support people was not robust nor was their system for ensuring staff demonstrated caring with dignity and respect.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

People received their medicines as they should but they were not always stored in line with instructions. People received support from staff when needed. People were cared for by staff who understood what it meant to keep people safe.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People were supported by staff who did not always understand which people were subject to a Deprivation of Liberty and therefore might have unlawfully restricted them. Staff caring for people received training and supervision and people were able to access support from other medical professionals when needed.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

People were cared for by staff who did not always show dignity and respect. People were not treated with kindness and compassion.

### Is the service responsive?

**Good**

The service was responsive

People's care was updated based on people's changing medical needs. People's individual interests were being supported.

### Is the service well-led?

**Requires Improvement**

The service was not always well led.

People's experience of care depended on where they lived within the home. Staff within the home worked to a unit and did not work as an overall team. Staff did not always understand people's care needs. The registered manager's system for ensuring high quality care was delivered was not always effective.

# The Boynes Care Centre

**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.

This inspection took place on 18 and 24th May 2016 and was unannounced. There were two Inspectors in the team and a one Specialist Advisor who was a registered nurse.

Before the inspection, the Provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We also spoke with the local Clinical Commissioning Group (CCG) for feedback.

We reviewed the information we held about the home and looked at the notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

As part of the inspection we spoke to seven people living at the service. We also spoke with four relatives, seven staff, the Registered Manager, the Registered Provider and the Head of Compliance. We observed care and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We reviewed three care records, the complaints folder, recruitment processes as well as monthly checks the management team completed.

Requires Improvement

# Is the service safe?

## Our findings

At our last inspection on 27 and 28 April 2015 people told us they did not get the care they needed because there were staff shortages. We rated this section as 'Requires Improvement.' At this inspection, whilst staffing levels were adequate, we could not be assured that other areas of the home relating to people's safety were acceptable.

We spoke with the registered manager about how they gained assurances that the nurses who worked at the home were registered to do so and had the required license to practice as nurses. She told us she completed six monthly checks to ensure nurses had an active registration on the NMC register. The Provider's last check was completed in September 2015, and eight months had elapsed since that check. On the second day of the visit, the registered manager gave us assurance that she had made the necessary checks. She went on to say that they would include this in their supervision so this could be monitored more regularly.

Despite people telling us they received their medication when they needed it, we identified concerns with how medicines were stored in line with the manufacturers' guidance. A nurse we spoke with confirmed room temperatures were taken for the storage room. However records we reviewed showed that for 14 consecutive days the room temperature taken by nurses was higher than the storage temperature indicated on instructions on some of the medicines and there was a risk that medicines would be damaged. When we spoke with the registered manager, she also confirmed she had not been made aware of the issues with medicines storage. Whilst the issue had previously been identified and a remedy sought, she told us they were not advised by nurses that the problem was persistent.

We reviewed a random sample of records to see how staff recorded when they had given tablets to people living at the home. Whilst the majority of records were completed satisfactorily we found the records for one person's particular medication could not be located. At the time staff were unclear whether they should be administering the medication or not. When the issue was highlighted to the management team, the nurse investigated the matter and the issue was resolved.

Staff were able to describe how they kept people safe and demonstrated their understanding of safeguarding. Staff told us about the safeguarding training they had received and what it meant to safeguard people who used the service. Notifications we reviewed as part of the inspection also confirmed that the registered manager understood their obligations with respect to keeping people safe and understood they could discuss their concerns or responsibilities with the local authority. The registered manager also understood her obligations and knew what needed to be reported. We reviewed notifications completed by the registered manager which had been completed in an appropriate and timely manner. One person told us they had had concerns and shared this with the registered manager who they felt had been "Very professional."

Staff we spoke with demonstrated a good understanding of how to keep people safe from harm. One staff member told us about their understanding of pressure sores and how to reduce the risk of pressure sores for

people who had been assessed to be at high risk. Another staff member understood that a person living at the service required support with their eye care. The staff member understood what they needed to do to support the person to reduce the person's risk of infection.

People and relatives we spoke with told us they felt staffing levels were adequate to keep people safe. This had improved from our last inspection. At that inspection people could not consistently access staff. One relative told us, "There's always plenty of staff around." On the day of our inspection we found staff were busy but that there was always a staff member around within communal areas if people needed help. We asked the registered manager how staffing levels were organised and staff deployed. They told us, staffing levels were based on occupancy levels as well as people's dependency. The registered manager told us that at the time of the inspection that some key staff were not available. However, she had worked with staff to cover different roles to ensure that people did not experience a reduction in service.

Requires Improvement

# Is the service effective?

## Our findings

During our previous inspection in May 2015 we found that staff did not always understand how people may not be able to make decisions for themselves and that care might be provided that unlawfully restricted people. We rated this section as Requires Improvement. At this inspection we found things had not improved.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We looked at how the registered manager made applications where people were assessed as having their freedom restricted. We also looked at how staff were kept updated when it had agreed with the Local Authority to deprive a person of their liberty to keep them safe. The registered manager told us that information about people's care needs was in the care plans. We checked and saw that information was available for care staff to review about people's individual applications and whether any deprivations were in place.

However, when we spoke with care staff their knowledge was inconsistent about who was subject to a Deprivation of Liberty. Whilst one staff member understood which people were affected and how, three care staff did not know who was affected by a Deprivation of Liberty and why. We spoke with two nurses about their knowledge of which people were affected by a deprivation and their knowledge was also limited. We could not be assured that people were not unlawfully deprived of their liberty because staff were unsure who was subject to a Deprivation of Liberty and how they were affected

This is a breach in Regulation 13 of the Health and Care Act 2008 (Regulated Activities) Regulation 2014.

Two relatives we spoke with were reassured by staff knowledge of their family member's care. Staff described to us training they were receiving to better support people. For example, one staff member had recently attended training on a manual handling course and was able to describe factors that needed to be taken into consideration and how best to care and support them. For example, how they should support people when transferring them. The staff member also told us that each person had their own individual sling which was used when transferring people. Other staff told us they had also received training and felt confident they could shared their training needs with the registered manager who would be supportive.

Although people we spoke with told us they liked the food, we saw that their mealtime experience was not always positive. People were all given the same pudding. We heard a member of the kitchen staff say, "They can all have this it's good for the purees and the softs". This was when the kitchen staff member was referring to people's individual diets and nutritional needs. People that required support to have a meal were given this support. Staff interaction with people over lunch was inconsistent. Some staff chatted to people over lunch whilst others were seen to support people without engaging with them. One staff member sat through a person's lunch without speaking to them.

People told is they were unwell or needed to see a Doctor staff would seek help for them. One person we asked about accessing additional help said they "Most definitely" got the help they needed. We saw during our inspection that the GP attended their round. One nurse we spoke with told us about information that was shared with the GP to ensure people received the support they needed. People also told us they attended hospital appointments with the support of staff as well as opticians appointments. Two relatives we spoke with told us their family member received support when needed as that additional help was sought when this was required.

Requires Improvement

# Is the service caring?

## Our findings

At our last inspection we found that the provider did not have effective arrangements in place to monitor and improve the quality, safety and welfare of people using the service. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider produced an action plan and we saw improvements at this inspection. However, we found other areas of improvement were required which related to staff practice around people's dignity and how they involved people in planning and influencing their care.

People's experience of being supported to maintain their independence and dignity, varied depending on where they lived within the home. The home was split into two units, the Cedar Unit, which supported people who were living with Dementia and the Malvern Unit, where people who had a specific health condition, Multiple Sclerosis (MS) lived or visited for respite care. We found that all staff we spoke with distinguished people by their health condition, rather than talking about people as individuals. Throughout the inspection, when we spoke with all staff or observed their practice, they referred to the "MS Unit" or the "Dementia Unit".

People who lived in the Cedar Unit received a more negative and inconsistent experience of care where their dignity was at times compromised. For example, we heard one person calling out for 20 minutes for a staff member to help them; they repeatedly called out, "Can somebody help me please. I need a blanket." We saw that there were two staff outside the bedroom within close proximity of the room. They were then joined by a nurse who walked past the person's bedroom and did not acknowledge the person's calls for help. At the insistence of one of the inspectors the nurse checked on the person. Upon the nurse entering the person's bedroom we heard the nurse say. "No wonder you were calling out, you need a blanket."

We saw inconsistent practices in how people were involved in making important decisions about their care. We spoke with one person who told us they preferred to have personal care provided by a same sex staff member, however told us they did not receive this. They said, "I have male carers. I really don't like it but I've got used to it." We asked the person if they had the opportunity to discuss their care preferences and have these confirmed and written down, however they told us they had not been actively involved in making these decisions about their care. We spoke with the registered manager to understand if the person's care needs had been discussed and updated, they confirmed they had. However when we reviewed the person's care records there was no record of the person's preferences. We had spoken with this person at our previous inspection in June 2015 where they raised the same concerns around their preferences.

Staff were task focused and would go from one task to another. Throughout the inspection it was found that staff used the lounge as a thoroughfare without little acknowledgment to people who were sat there. We saw five people sitting in the lounge of the Cedar Unit, when we walked in we saw one member of staff sitting reading a newspaper. We did not see the staff member engage or try and interact with any of the people whilst we remained there.

One Inspector saw a care staff member enter a room, the person's window was open and they had their

blanket held tightly around them to keep in the warmth. A staff member entering the room was focussed on their task and left a drink for the person without acknowledging them or asking if they needed anything further. When the Inspector asked the person whether they wanted the window closed, they indicated that they did.

On another occasion a staff member was seen discussing the people they supported to have their lunch and shouted out across the dining room, "When I've finished [person's name] we can do [person name])." Throughout the home and in people's bathrooms and toilets we found that the hand gel was in containers that were appropriate for children. The wall mounted units had had written on them, "Mr Soapy says please wash your hands" which was not dignified or respectful language for the people who used the service.

This was a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014.

People were supported to maintain relationships with people who were important to them. We saw relatives visit their family members throughout the day. One relative told us they visited frequently. Relatives told us that they were able to visit whenever they chose and that care staff kept them up to date about their family member's condition.

Good

# Is the service responsive?

## Our findings

People we spoke with told us they were supported to maintain their personal interests. A relative told us they discussed their family member's care needs before their relative moved into the home and made staff aware of things about their family members care that they needed to know. They told us they listed things that were important to them. Another person told us they had worked with staff since moving to the home to adapt their bedroom and made changes to make the bedroom more in keeping with how they wanted to live. A further person told us they enjoyed going out on day trips and that they looked forward to these. We saw staff supporting people to visit the city centre on a day trip. People looked pleased to be attending and were smiling and chatting to staff. One person we spoke with told about how they spiritual needs were important to them and that they supported to maintain this support from their local place of worship.

People we spoke with told us that as their care needs changed, amendments were made to their care. One person described their condition as progressive and that they could experience periods when they required additional help. They told us "we discuss my care and we agree things." Another relative we spoke with told us their family member had lived there for sometime and that they had discussed their care with the registered manager and changes had been made to their family member's care. They described having had a wheel chair changed when the person required this.

People and their families understood they could complain if they needed to. People understood they could speak to staff or the registered manager if they needed. One person told us they had spoken to the registered manager and asked for changes to be made to things they were not happy with. They told us these had all been actioned and resolved. We reviewed how the provider recorded complaints and saw there was a policy in place. People's complaints were acknowledged and responded to in a timely way. Details of the complaints were shared with the registered provider for them to review. We saw that one person had made a complaint about wanting to go to bed earlier and the registered manager had met with them and resolved the complaint.

Requires Improvement

# Is the service well-led?

## Our findings

At our last inspection in April 2015 we identified that there were issues with governance and that the home was not consistently well led. A lack of leadership was identified because of the absence of a registered manager at the home and the numerous interim arrangements. At the last inspection we identified that systems for auditing people's care needed to be improved. Although the registered provider had recently recruited a Head of Compliance in January 2016 and checks were being made, the checks relied on strong leadership within the home. At this inspection we could not be assured that there was a strong leadership in place to drive change and found there were systematic issues in the home which meant people's experience of care was not positive.

Staff interaction with people had already been identified as an issue and was being monitored. We observed how staff spoke about people in some areas of the home . Whilst some care staff diligently attended to people other staff did not have insight in to their behaviour or the distress this may have caused people. The provider's tool for monitoring behaviour had identified improvements; we did not see that this was consistent across the home.

Staff we spoke with identified with their units and there was a strong sense of solidarity within the unit they worked for although this did not always extend to the home as a whole. One staff member who worked within the Malvern Unit told us, "We are a close team on the MS Unit." When we spoke with staff and asked what they did, each would mention the unit they worked for and say they did not necessarily know about the workings of the other units. Staff we spoke with could tell us about how their unit operated but were not always knowledgeable about the other unit or people that lived within the unit. However, staff told us they routinely covered shifts in the other units but did not always know specific details about people's care. One such example included how some people may be affected by a Deprivation of Liberty.

The registered manager's system for reviewing and updating care was not always effective. The registered manager relied on the nurses to fulfil their role and the deputy manager to fulfil both a nursing and deputy manager's roles. However, the system for reviewing performance required improvement. The registered manager told us it was the responsibility of nurses to review care plans and documentation. We looked at the records for how often one person needed be turned to prevent them from getting sore skin. We identified that there was no clear guidance on the turn chart and when asked this could not be located in other documents. We raised the issue of the turn charts with a member of the management team, who acknowledged improvements were required.

We noted that the Registered Manager was not aware of all issues within the home affecting people's care, some of which had not been shared with her by staff. We noted there were communication issues within the home and that information was not always shared appropriately. Information relating to concerns about the appropriate storage of medicines was not shared with the registered manager despite staff knowing that storage temperatures were an issue. Gaps in staff knowledge were noted when discussing people's individual routines and whether they were subject to a Deprivation of Liberty. We could not be assured that when staff covered in other units, that they understood how to care for people or that staff working within

their own units had the appropriate knowledge. People's care plans were stored on computers for staff to access. During our inspection both care staff and nurses highlighted difficulties they had accessing the information held on the computers. Staff we spoke with complained that they were not able to access computers when they needed as there were not enough computers. Staff we spoke with expressed frustration because they could not access information held in people's care plans when needed. There were five computers to use across the home which included access by the registered manager, nurses and care staff across two units.

We found delays in the length of time taken to verify the registration status of their nurses. The provider acknowledged that checks should occur more frequently and assured us that this would be included within their own monitoring systems.

The registered provider had sought to gather opinions from people and their family through questionnaires that had been sent out. A poor response had been received and they were now looking to develop alternative ways in which to discuss with people what they thought about the home.

The registered manager and Head of Compliance acknowledged that there were issues at the home and were working together on a Continuous Improvement Plan. Some of the issues raised in the inspection were mirrored in the provider's Improvement Plan. We saw some examples where additional actions would be required. The registered provider assured us that plans were in place to address concerns and that the Head of Compliance would be supporting the home.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People were not being cared for with dignity and respect. People's experience of care depended on where they lived within the home and staff were task focussed |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>People were supported by staff that did not understand or know which people were affected by a Deprivation of Liberty. |