Northamptonshire County Council

Boniface House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on the 20 August 2018 and was unannounced.

Boniface House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Boniface House accommodates up to 46 older people in a purpose-built building which has six individual units all on the ground floor. Each unit had its own facilities and people lived in the unit which best met their needs. At the time of our inspection there were 44 people staying there.

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 2008 and associated Regulations about how the service is run.

There were not always sufficient staff to meet people's holistic needs in a safe and timely way. We have made a recommendation about improving the staffing levels.

People received care from staff that knew them and were kind, compassionate and respectful. Care at times was task focussed and there was limited interaction with people outside of completing care tasks.

People's needs were assessed prior to coming to the home and detailed person-centred care plans were in place and were kept under review. Risks to people had been identified and measures put in place to mitigate any risk.

There were appropriate recruitment processes in place and people felt safe in the home. Staff understood their responsibilities to keep people safe from any risk or harm and knew how to respond if they had any concerns.

Staff were supported through regular supervisions and undertook training which helped them to understand the needs of the people they were supporting.

People were involved in decisions about the way in which their care and support was provided. Staff understood the need to undertake specific assessments where people lacked capacity to consent to their care and / or their day to day routines.

People were cared for by staff who were respectful of their dignity and who demonstrated an understanding of each person's needs. This was evident in the way staff spoke to people and the activities they engaged in with individuals.

Relatives spoke positively about the care their relative received and felt that they could approach management and staff to discuss any issues or concerns they had.

People's health care and nutritional needs were carefully considered and relevant health care professionals were appropriately involved in people's care.

There were comprehensive systems in place to monitor the quality and standard of the home. Regular audits were undertaken and any shortfalls addressed.

The registered manager was approachable and people felt confident that any issues or concerns raised would be addressed and appropriate action taken.

The service strived to remain up to date with legislation and best practice and worked with outside agencies to continuously look at ways to improve the experience for people.

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.

There was not always sufficient staff deployed to provided holistic care in a timely and safe way.

People told us they felt safe and there were risk assessments in place to mitigate any identified risks to people.

There were safe systems in place for the administration of medicines and people could be assured they were cared for by staff who understood their responsibilities to keep them safe.

Is the service effective?

Good

The service was effective.

People received support from staff that had the skills and experience to meet their needs and who received regular supervision and support.

People were involved in decisions about the way their support was delivered; staff understood their roles and responsibilities in relation to assessing people's capacity to make decisions about their care.

People had access to a healthy balanced diet and their health care needs were regularly monitored.

Is the service caring?

Good

The service was caring

Positive relationships had developed between people and staff. People were treated with kindness and respect

People could make choices and decisions about their care and their dignity was protected.

Visitors were welcomed at any time.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they came to stay at the home to ensure that all their individual needs could be met.

People were encouraged to maintain their interests and take part in activities.

People were aware that they could raise a concern about their care and there was written information provided on how to make a complaint.

Is the service well-led?

Good

The service was well-led

There was an open and inclusive culture which focussed on providing person-centred care.

There were effective systems in place to monitor the quality of care and actions were taken whenever shortfalls were identified.

People and staff were encouraged to give their feedback and be involved in the development of the home.

Boniface House

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 20 August 2018 and was unannounced. The inspection was undertaken by one inspector, an assistant 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 service. In this instance the expert by experience had experience of caring for a relative living with dementia and supporting older relatives to access similar services.

Before the inspection, we checked the information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law.

We also contacted the health and social care commissioners who help place and monitor the care of people living in the home.

During our inspection we spoke with eight people who lived in the home, 10 members of staff including five care staff, two shift leaders, two team leaders and a domestic, plus the registered manager. We were also able to speak to three relatives and a friend of a person at the home, who was visiting at the time.

We observed care and support in communal areas including lunch being served. Several people who used the service lived with a dementia related illness and so some of them could not describe their views of what the service was like.

We looked at the care records of four people and three staff recruitment records. We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, maintenance schedules, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

Requires Improvement

Is the service safe?

Our findings

Improvements were required to the number of staff deployed. There was a care assistant deployed in each unit where there was between seven and eight people living there, however, if a person required assistance from two care staff it meant that a care assistant from one unit had to go and assist, this left people unsupervised and without assistance. The registered manager explained to us that there were two shift leaders whose role included supporting the care staff as and when required. However, the shift leaders were also responsible for medicine administration which meant at times they would be unavailable. On the day of the inspection the shift leaders were also covering in the laundry as the laundry assistant was away.

The staff were stretched and people were left waiting for assistance. We observed one person almost falling out of the side of their chair and there were no staff insight to support them. Another person was left waiting for up to half an hour after finishing their breakfast before care staff were available to assist them. One person was only finishing their breakfast at 11.45am and dinner was served from 12.30pm. The person had required the support of two staff to assist them so had had to wait for staff to be available.

Staff told us that they did not always feel there was enough of them and that they had limited time to spend with people outside of delivering care. The people who could speak to told us they accepted that staff were busy and that they would have to wait.

We spoke to the registered manager who explained there was a dependency tool in place which assisted them to identify the level of staffing required. Currently, the home had reached the maximum level of those people requiring the support of two people.

We recommend that the provider reviews how it determines the level of staff required to ensure that people receive holistic care in a timely and safe way.

People looked relaxed and comfortable in the presence of the staff. People told us they felt safe in the home. One person said, "I am safe here, they look after you, and make sure you are fed well and kept all right." A relative said, "We feel it is safe here, we come in regular and never have any reason to think not to. "

Staff understood their roles and responsibilities in relation to keeping people safe and knew how to report concerns if they had any. One member of staff told us "I would report any concerns to the managers." We saw from staff training records that all the staff had undertaken training in safeguarding and that this was due to be refreshed for some staff. There was an up to date policy and the contact details of the local safeguarding team was readily available to staff. The registered manager had contacted the local safeguarding team when any concerns had been raised. Where the local authority had requested investigations to be undertaken these had been done so in a timely matter. Any lessons learnt had been recorded and shared with staff.

There were a range of individual risk assessments in place to identify areas where people may need additional support to manage their safety. For example, people identified as being at risk of damage to their

skin due to pressure or who were at nutritional risk had been assessed; appropriate controls had been put in place to reduce and manage the risks. Records showed that the care specified had been provided for example people were supported to change their position regularly and had their food and fluid intake monitored to ensure their well-being. The information recorded for each person was kept up to date and was regularly collated which helped the registered manager to monitor people's general health and well-being and keep them safe.

People were safeguarded against the risk of being cared for by unsuitable staff because there were appropriate recruitment practices in place. All staff had been checked for any criminal convictions and satisfactory employment references had been obtained before they started work at the home.

People received their medicines, as prescribed, in a safe way and in line with the home's policy and procedure. We saw staff spent time with people explaining their medication and ensuring they had taken their medicines. One person said, "I get my medicines when I should. It's a pattern every day, morning and evening around the same time every day." Medicine records provided staff with information about a person's medicines and how they preferred to take them. There was also information about medicines people could take on a flexible basis, if they were required and when and how they should be used. People's medicine was stored securely in a locked cabinet.

Staff competencies to administer medicines were tested on a regular basis and audits of the medicines undertaken. If any issues were identified they were dealt with in a timely fashion to ensure medicine errors did not happen, and if they did they could be rectified. There was a system in place to safely dispose of any unused medicines.

There were regular health and safety audits in place and fire alarm tests were carried out each week. Each person had a personal evacuation plan in place. Equipment used to support people, such as hoists were stored safely and regularly maintained. Hoist slings were clean and odour free.

Any accidents/incidents had been recorded and appropriate notifications had been made. The registered manager collated the information around falls and accidents/incidents monthly and took action as appropriate. We saw that one person who had an increase in falls had an action for a sensor mat to be placed by her bed so that staff were alerted in the night if they got off the bed; we followed this up and saw it had been put in place and the number of falls the person had had, significantly reduced.

The home was clean and free from any unpleasant odours. The staff wore protective clothing when required and there was information around the home for people, staff and visitors in relation to infection control. The provider had systems in place to monitor the cleanliness of the home and all staff received regular training in relation to infection control. However, we did observe one member of staff not following the infection control guidance, when we brought this to their attention they took action to address this. The registered manager needed to ensure that all staff consistently followed the guidance given.

Good

Is the service effective?

Our findings

People's care was effectively assessed to identify the support they required. Each person received a pre-assessment of their needs before they moved into the home which ensured that they moved in to the area of the home which could best meet their individual needs.

The home liaised with other health professionals which ensured people's health care needs were met. A GP visited each week and District Nurses visited when needed. One person said, "The GP comes if I need them." We saw from people's care records that when health professionals had visited this was recorded and any action required followed up. For example, a person had been referred to a dietitian when their weight loss had been identified.

People were supported and cared for by a well-trained staff team. People were confident that the staff had the skills and knowledge to support them. One person said, "I think the staff are well-trained, they seem to know what they are doing." A relative said "[relative] needs to use a hoist, all the staff seem to know what they are doing, they are very good."

All new staff undertook a thorough induction programme which was specifically tailored to their roles and experience. The induction consisted of two weeks of classroom and eLearning which included moving and handling, fire safety, equality and diversity, safeguarding, infection control, dementia awareness, medication administration. The staff then completed a period of shadowing permanent more experienced staff members. One member of the care staff said, "You were not dumped in at the deep end. I had two weeks of training initially and then I shadowed more experienced staff for about four weeks in the end, until I felt confident."

Staff were supported to obtain professional qualifications; some staff had National Vocational Qualifications up to level 5 and all staff were encouraged to undertake further training to enhance their knowledge and skills. Ongoing training included end of life care, care planning, dementia awareness and infection control. There was a staff training matrix in place so it was clear for the registered manager when refresher training was required. This ensured that all staff remained up to date with their training.

Staff felt supported and listened to. Staff told us they received regular supervision and had annual appraisals and records confirmed this.

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 decisions 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 procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and we saw that they were. The registered manager and staff were aware of their responsibilities under the MCA and the DoLS Code of Practice. We saw that DoLS applications had been made for people who had restrictions made on their freedom and the management team were waiting for the formal assessments to take place by the appropriate professionals. Best interest decisions were recorded in care plans where people were unable to consent to medication. Choices and preference were clear in peoples care plans including where people had varied capacity. We saw paperwork and care planning that guided staff to always ask a person about choices. Care plans had been signed by people or if applicable their relatives.

People were involved in decisions about the way their support was delivered. We saw that staff sought people's consent before they undertook any care or support. For example, we heard one member of staff say, "[Name of person] I have a drink for you, do you want it?"

People were regularly assessed for their risk of not eating and drinking enough; staff used a tool to inform them of the level of risk which included monitoring people's weight. A daily record was kept for each person assessed at being at risk of not eating or drinking enough which demonstrated that staff monitored people's fluid and food intake. However, we found that not all records contained a target for the individual, the registered manager needed to ensure that targets were agreed and consistently recorded. If there were any concerns about people not getting enough nourishment this was discussed at a daily meeting and referrals had been made to the dietitian for advice and guidance.

People were supported to eat a healthy balanced diet. There was a choice of meals available each day; the cook could offer alternatives if someone did not like what was on the menu. People were asked regularly at resident's meetings about the food. People told us they like the food and could have an alternative if they did not want what was on the menu. One person said, "I enjoy the food; I would send it back if I did not like it or order it." A relative said, "As far as we know the meals are quite good and [relative] eats everything that's given. They wouldn't eat it if they didn't like it. They have a good appetite."

People could choose whether they ate in one of the dining areas, lounge or in their own rooms. Staff were stretched at times trying to support people, but were attentive to people's needs. There was specialised equipment available to help people remain independent. The dining experience could be improved as there was very little opportunity for staff and people to interact. The cook was regularly updated on any special dietary requirements, the need for fortified foods and any specific likes or dislikes for people. There were drinks, fruit and snacks available throughout the day.

Boniface House is a purpose-built home which enabled people to access all areas. There was accessible garden space for people to use and people had space for privacy when they wanted it. People had been encouraged to personalise their bedrooms; people had brought in personal items from their own home when they had moved in which had helped them in feeling settled in the home. There were a number of people living with dementia and the provider had developed areas which helped to engage with people such as an area with old style food products, this could be enhanced further with consideration of more dementia friendly signage and the use of different floor coverings to help people to remain as independent as possible.

Good

Is the service caring?

Our findings

There was a friendly and welcoming atmosphere around the home. People looked happy and relaxed and we observed positive relationships between people and staff. Some of the comments made to us about the staff by people included "The staff are very good." "They [staff] are good and look after me." One relative said "The staff are brilliant."

People's individuality was respected and staff responded to people by their chosen name. In our observations of and conversations with staff, it was clear they knew people well and understood their individual needs. They spoke fondly of people and could explain people's likes and dislikes to us. Interactions tended to be task focussed due to the number of staff deployed.

Care plans contained detailed information to inform staff of people's history, likes and dislikes, their preferences as to how they wished to be cared for and their cultural and spiritual needs. This meant staff could have meaningful conversations with people when they got the opportunity to do so.

People were supported by staff to maintain their personal relationships. This was based on staff understanding who was important to the person, their life history, and their cultural background. We saw that when people in a relationship lived at the home the registered manager had ensured that they had an area for themselves to sit and spend time with each other in private.

People were valued and encouraged to express their views and to make choices. We saw staff offering people the choice as to where they sat or whether they wished to participate in an activity. One person said, "I could go out if I wanted." Another person said, "Last night I wanted to watch the television and they brought me a cup of hot chocolate and biscuits."

Staff spoke politely to people and protected people's dignity. We saw staff knocking on bedroom doors before entering and people had been asked whether or not they preferred their bedroom door to be left open or not. One relative said, "[Relative] is able to lock their door when they are using the commode, staff are respectful." We observed someone being hoisted from a chair into a wheelchair, throughout the staff spoke to the person and put them at ease, they ensured their dignity was maintained as they arranged the persons clothes, the person looked at ease.

People's spiritual and cultural needs were being met. If people were able they attended their local church and the home had arranged for a local faith leader to visit the home on a regular basis.

The people who were unable to communicate with us looked relaxed around staff. Staff were attentive and sat or knelt by people touching their hand when trying to communicate with them and explaining the care they were being given. Staff spoke softly to people and were mindful to protect people's confidentiality.

If people were unable to make decisions for themselves and had no relatives to support them, the provider had ensured that an advocate would be sought to support them. An advocate is an independent person

who can help people to understand their rights and choices and assist them to speak up about the service they receive. At the time of the inspection there was no one who needed an advocate.

Throughout the day of the inspection family and friends were welcomed as they visited their loved one. Relatives and friends could visit at any time. One relative said, "I can visit at any time, I am always welcomed."

Good

Is the service responsive?

Our findings

People's needs were assessed before they came to live at Boniface House to ensure that all their individual needs could be met. People and their families were encouraged to visit the home if possible before making the decision as to whether to live there. We saw the pre-admission information was used to develop a person-centred care plan which detailed what care and support people needed and their likes and preferences.

The care plans contained all the relevant information that was needed to provide the care and support for the individual and gave guidance to staff on everyone's care needs. The care plans were reviewed monthly or more often if things changed. One person told us, "We have a review every so often where [registered manager] sees me and the social worker. "

Staff demonstrated a good understanding of each person in the home and clearly understood their care and support needs. For example, a member of staff explained about taking time to coax a person out of bed; they said it is important that people do move and not stay in bed all day unless they are ill, [name of person] often just need a little encouragement and time. One person said, "The staff all know and the newer ones are getting to know me."

People's needs were continually kept under review and relevant assessments were carried out to help support their care provision. These included assessment of skin integrity and where necessary people were provided with appropriate pressure relieving equipment and were supported to change their position regularly. We saw that adjustable levels of the pressure relieving mattresses were set to the needs of each person.

Records kept detailed when they had been moved or repositioned, what people had drunk and what personal care needs had been undertaken. The registered manager did need to ensure that records were consistently maintained and targets set for people at risk of losing weight.

The home continued to care for people at the end of their lives. The home had achieved a bronze award in end of live care and liaised with a local hospice. There was detailed guidance in people's care plans to support staff as to how to care for people at the end of life. This was a sensitive issue which staff supported people with at the appropriate time. If people were happy to discuss this a care plan was in place and any advanced decisions recorded. Staff received training in end of life care. We spoke to staff about their understanding of providing end of life care, they spoke about following people's wishes, making sure they were kept comfortable and supporting their families. At the time of the inspection there was no one receiving end of life care.

People were encouraged to follow their interests and take part in activities. One person told us they liked to go out shopping and that the staff supported them to do this. People told us there were enough activities they could do if they wished. We saw that there was a monthly newsletter, 'Boniface Bugle', which detailed activities and events for the month. Activities included, music and movement, bingo, games morning and

cheese and wine evening. These could be strengthened further with more individualised activities. There was a bar and each Saturday they had a happy hour. One relative said, "[Relative] used to take part in all the activities but not so much now, they always ask them though."

The service looked at ways to make sure people had access to the information they needed in a way they could understand it to comply with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. Information was available in large print for people with visual impairments.

People were aware that they could raise a concern about their care and there was written information provided on how to make a complaint. Relatives said that the registered manager was approachable and that if they had any concerns they would speak to them. One person said, "I made a complaint about a year ago, it was sorted out straight away."

The registered manager told us that they tried to resolve any concerns as quickly as possible and we saw that where complaints had been raised the registered manager had responded promptly and sought the relevant advice and support to resolve things and action plans were in place to address any learning. For example, when toiletries had gone missing, new products were bought and labelled to ensure they stayed with the person.

Good

Is the service well-led?

Our findings

People were supported by a team of staff that had the managerial guidance and support they needed to do their job. The registered manager was visible and approachable and the provider visited regularly. We saw that people were comfortable and relaxed with the registered manager and all the staff.

We received positive comments from people and staff about the home and how it was managed and led. One person said, "[Registered manager] is very approachable, she was even helping out in the laundry the other day." A relative said, "If I had any concerns I would talk to [Registered manager], I know who they are."

Staff demonstrated knowledge of all aspects of the service and the people using the service. There was a clear emphasis on treating people as individuals and supporting them with care that was tailored to their needs.

There was a culture of openness and transparency demonstrated by the provider's proactive approach in encouraging people and their families to feedback about the service and listening to staff.

There were regular meetings with the people living in the home. We saw from minutes of meetings that people were asked about the menu, the quality of the food, food choices and size of portions, also about what activities people may like and forth coming events. The meeting gave everyone the opportunity to share ideas about the service. Staff meetings too were held regularly. One member of staff told us, "We are encouraged to share ideas. One suggestion was to hold coffee mornings for everyone to enjoy." We saw that regular coffee mornings were held which involved families and friends.

There were systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service. People were assured of receiving care in a home that was competently managed on a daily as well as long-term basis.

Records relating to the day-to-day management and maintenance of the home were kept up-to-date and individual care records we looked at reflected the care each person received. Staff understood their responsibilities in relation to equalities and diversity, 'whistleblowing' and safeguarding and there were up to date policies and procedures to support them.

The provider understood their responsibilities in relation to supporting a diverse staff team. They ensured that staff and people were treated equally to ensure they had the same chances as each other. For example, when a new member of staff had been recruited who had communication difficulties, the registered manager had ensured they had all the resources and equipment they needed to assist them to fulfil their role.

Quality assurance audits were completed by the registered manager and the provider. The provider made regular visits and followed up on any actions that had been identified through audits. The provider ensured that the systems in place to monitor the home were effective. The audits and visits helped to ensure quality

standards were maintained and legislation complied with. Where audits had identified shortfalls, actions had been carried out to address and resolve them; for example, it was identified that communication with staff was not always effective so in addition to the regular staff meetings group staff supervisions have been put in place.

The Quality Assurance system could be strengthened further to include observing people's experience of life in the home. This would help to identify how best to deploy staff to be able to provide more interaction outside of care delivery and enhance person-centred care.

To ensure that the managers and staff were kept up to date with changes in practices, legislation and new innovative ways to deliver care, the provider and registered manager attended various conferences and workshops, received information from other agencies and medical alerts which was cascaded to staff through training programmes.

At the time of the inspection the service had worked with the NHS Corby Clinical Commissioning Group looking at ways to improve care for frail older people by use of a new Frail Toolkit. Identified staff had received specialist training which was due to be cascaded to the rest of the staff team.

The home developed links with the local community and families. There were volunteers who supported the home to maintain its gardens and people were supported to visit local coffee shops and the library local group.