Care Quality Commission

Oldfield Residential Care Ltd

Bluebrooke Residential Care Home

Inspection report

242 Stourbridge Road
Bromsgrove, Worcestershire
Tel:01527 877152
Website: www.oldfieldcare.co.uk

Date of inspection visit: 13 and 16 February 2015
Date of publication: 24/06/2015

Ratings

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

Overall summary

The inspection took place on 13 and 16 February 2015 and was unannounced.

Bluebrooke Residential Care Home provides accommodation for up to 43 older people who require personal care who may have a physical illness or are living with dementia. There were 42 people living at the home.

When we visited a new manager, who had previously worked at the service had taken over. The manager was in the process of applying to become the 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

There were some systems in place to monitor the infection control at the service but these were not always effective. Staff were seen using a bathroom with no access to a sink.

People were positive about the care they received and about the staff who looked after them.

People told us that they felt safe and staff gave us examples of how they kept people safe. During our inspection we observed that staff were available to meet people's care and social needs. People received their medicines as prescribed and at the correct time and medications were safely administered and stored.

We saw that privacy and dignity were respected. Throughout the inspection people were supported to do things which were important to them. Staff showed a good understand of how to ensure that people's right were maintained. Where people did not have capacity to make such decisions, staff knew how to support people and the processes to the follow to ensure their rights were not compromised.

We found that people's health care needs were assessed, care planned and delivered to meet those needs. People had access to other healthcare professionals that provided treatment, advice and guidance to support their health needs. Families told us that they felt that further help was sought when needed.

People had access to choices at mealtimes. However, were support was required, this was not always provided because of the way the staff were deployed to cover the mealtimes.

People received support from staff who received regular training and understood their needs. The registered manager told us that all staff training was regularly reviewed and regular checks were made to ensure that everyone received the right training.

People and staff told us that they would raise concerns with senior staff and the registered manager or the provider and were confident that any concerns would be dealt with. The operations manager for the service regularly met with the manager to discuss the service and ways to improve it.

The manager undertook regular checks to ensure that the quality of the care could be monitored and improvements made where required. However, not all systems were effective to ensure that service delivery was consistent throughout the home.

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 were not safe from the spread of infection because systems were not effective.

People's care needs were not consistently met as the deployment of the staff meant it was not possible to determine their responsibilities for support. People received the appropriate medication and this was stored and disposed correctly.

Requires improvement

Is the service effective?
The service was not always effective

People's needs were met by staff who had the appropriate skills and knowledge to ensure people received effective care. However, people were not always supported to have sufficient to eat and drink as staff were not always deployed in a manner to ensure people received effective care.

Requires improvement

Is the service caring?
The service was caring.

People were supported by staff who treated them with kindness, dignity and respect. People and those important to them were involved in planning how their care was delivered.

Good

Is the service responsive?
The service was responsive.

People knew how to raise concerns and felt confident that these would be listened to and acted upon. People's wishes regarding their care were taken into consideration and the provider used feedback to learn from incidents and improve the service

Good

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

People did not always receive a well led service because care teams were not always effectively organised to ensure that high quality care could be delivered.

There were some systems at the service for monitoring and improving quality but these were effective in helping the provider to measure quality and improve the service.

Requires improvement

Bluebrooke 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 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.

There were two inspectors in our inspection team and the inspection took place on 13 and 16 February 2015.

Before our inspection, we looked at and reviewed notifications that the provider had sent us. Notifications are reports that the provider is required to send to us to inform us about incidents that took place at the service, such as an accident or a serious injury. We also spoke with the Local Authority.

During the inspection, we spoke with six people who lived at the home. We also spoke with three care staff, the clinical lead, the registered manager, the operations manager as well as the clinical lead from another service run by the provider. We also spoke to five relatives.

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 looked at two records about people's care, staff duty rosters, complaint files and audits about how the home was monitored.

Requires improvement

Is the service safe?

Our findings

At this inspection we found some concerns with how infection control was being managed. We looked at bathrooms as well as communal areas used by people and staff at the service. We saw that the staff bathroom did not have access to a sink. Staff told us that they had to go into another area of the home to wash their hand after using the bathroom facilities. When the manager was asked about this, we were told that staff were not supposed to use the toilet due to its lack of a sink. However, there was nothing preventing staff from accessing the toilet. No signage preventing access could be seen and staff were not aware that they should not use the bathroom. We could not therefore be assured that infection control was being kept to a minimum. The manager assured us that the matter would be rectified immediately. The manager also told us that an 'Infection Control' lead had recently been appointed but was awaiting further training.

We looked at staffing levels in the service. Although relatives and staff told us they felt there were enough staff, from observations it was noted that staff were not always available to support people when they needed assistance. For example, one person was observed asking to change their trousers, which they said "Make me uncomfortable". Several hours later the person was seen still asking for the trousers to be changed. Once the trousers had been changed, the person was far more settled. We also noted that often there were long gaps between which care staff popped in and checked up on people in the lounge because they were already occupied with other duties. Some gaps were as much as 25 minutes. Some people were seen having spilt a drink on themselves or were becoming unsettled. Although people did not necessarily need the support of a dedicated care worker, there were times throughout the day when there were a large number of people in the lounge without access to a care worker. We were not assured that people could access a call bell in the lounge if needed in order to summon help. The system for reviewing staffing levels was largely determined by the needs of the people being cared for. When we raised our observations with the manager, they agreed to take on board the issues raised and stated that they were already working to improve things at the service.

A number of staff had recently been recruited on a permanent basis in order to reduce the reliance on agency staff and ensure consistency. Staff were able to tell us about their induction and about how their competency was assessed and how they were gradually introduced to their roles and familiarised themselves with the people they cared for.

People we spoke to told us that they felt safe. One person said, "Yes I feel safe". They continued by telling us how they 'loved' the care staff. Relatives told us they felt their relatives were safe.

People told us that they felt safe because people knew that they could talk to staff about issues concerning their safety and because staff understood how to keep people safe. One person told us if they had any concerns they would, "Speak to the manager or speak to staff." All staff we spoke with told us how they would respond to allegations or incidents of abuse, and also knew who to report concerns to in the home. Staff told us that they were confident to report any suspicions they might have about possible abuse of people who lived at the home. They confirmed that they had an understanding of adult protection and had received training. They also confirmed that they could approach external organisations for help.

Plans were in place that ensured staff had information to keep people safe. Where a risk had been identified, care records detailed how to minimise or manage the risk. For example, where people had a risk of falls, appropriate information had been recorded in order to manage the risk of falling again. Staff knew to refer to the details in the care plan for more specific information but could also relay what risks the person faced and how they would minimise those risks. For example one staff member had just returned from holiday and told us how they got updates from other staff, speaking with the person or their family or checking the person's file.

We observed a medication round during our inspection. The safe storage and disposal of medications was also looked at. The Medical Administration Records (MAR) had been completed to show when people had received the medicines. The provider had systems in place for the appropriate storage and disposal of medicines. The manager told us how she regularly observed staff giving medications to make sure they were doing it safely and in line with the provider's policy. A local pharmacist visited regularly to audit the medication systems. When they had identified actions, the manager had took steps to resolve the issues and these had been rectified.

Requires improvement

Is the service effective?

Our findings

We reviewed how people received their meals and whether they were supported adequately. The meal time experience was at times chaotic. The dining area was split into two with further people receiving meals in the lounge. Some people required more support than others and staff were seen offering people spoons full of food as they walked past people while trying to support a number of people. Staff whilst trying to focus on ensuring people received their food did not always engage people in conversation or were able to check if people needed anything further.

We saw that people were seated for almost 30 minutes before the first course arrived and were heard repeatedly asking "Where's my dinner?" And "Where's my fish and chips?" The delay in part was caused by staff trying to support everyone at the same time and some people required more support than others. One person was observed struggling to eat their food and this was not noticed by staff. Another person was observed taking food from another person's plate. People experienced a delay before the dessert was served and some people got up and left the table before it was served.

For people requiring greater assistance, they were supported. However, people with less obvious needs were not adequately assisted. Some people were observed leaving their meals because they hadn't seen the food and required prompting or because they had become distracted by other events in the dining area. When we raised this with the manager, they could not give an adequate explanation. Although there were no concerns about people's weight , we were not assured that people had a positive dining experience.

We looked at three people's care records and saw that dietary needs had been assessed. The information about each person's food preferences had been recorded for staff to refer to. Staff told us about the food people liked, disliked and any specialised diets. Care plans also contained regular monthly weights for people as well as the appropriate action taken when there were concerns for people's weight. A dietician had recently reviewed a number of people to ensure that records and care required for people was accurate. Systems were in place to monitor this and escalate to a GP if required.

We spoke with staff and they told us they felt supported in their role and had regular conversations with their manager to discuss their role and their performance. One staff member told us, "It's a two way conversation. You can bring anything up." Staff we spoke to were happy in their role and felt that support was given to them in order to do the job. People we spoke to were happy with the staff and felt that they understood their needs. One family told us about difficulty they had experienced caring for their relative but that staff understood how to respond to their relative and since entering the service, their condition had settled and they felt reassured by their family member's progress.

Staff training was regularly audited and future training courses had been booked. The registered manager showed us how they kept their staff knowledge up to date. All staff described the induction as thorough. For example, one staff member said, "There's a lot of training you can ask for." Staff gave us examples of how their dementia training had given them a better understanding of people living with dementia.

We looked at how the Mental Capacity Act (2005) had been implemented. This is a law that provides a system of assessment and decision making to protect people who do not have capacity to give their consent. We also looked at Deprivation of Liberty Safeguards (DoLS) which aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

All staff we spoke with told us they were aware of a person's right to choose or refuse care. They were able to tell us about what safeguards needed to be in place when people could not make decisions for themselves. Staff were able to tell us about equipment like handrails on beds could restrict people's movement and if they were needed for people's safety that the decision was properly discussed and recorded. They told us they would refer any issues about people's choice or restrictions to the registered manager or senior care staff on duty and capacity assessments were noted from care plans.

People's care had been regularly monitored and people told us that they were involved in discussions about their care together with their families. One family told us about how their relative's changing health and how they regularly chatted to staff to understand what was going on. The relative told us about how the Social Worker had also been involved in discussions with them and that they were

Requires improvement

Is the service effective?

working together to care for their relative. We also spoke to staff about referring to a Doctor when appropriate and staff described to us when they would raise concerns. We also reviewed handovers from staff which detailed how concerns were raised, acknowledged and acted upon. We were also able to see a person leaving to attend a hospital appointment which illustrated to us that people received other health support when needed.

Good

Is the service caring?

Our findings

People told us they felt cared for. One person said, “They look after me really well here”, whilst another said, “It’s very caring here.” One relative also described the care staff as “Brilliant.”

We saw staff supporting people throughout the day in a caring manner and interacting people in a positive way. Staff chatted and laughed with people. There was lots of light hearted conversations and people responded positively to these. People knew staff names and addressed them with a sense of familiarity. We saw people laugh and approach staff to chat to them.

People chose were they wanted to spend their time. Some people chose to sit in a quiet lounge whilst other sat in the larger lounge and either watched TV or sat and chatted to other people. Peoples care needs were understood by staff. One person was observed to be agitated at times and restless and staff understood how to engage with them and distract them. Another person was observed in night clothes. When we queried this with both staff and family members, family members assured us that their relative chose to be dressed in night clothes through preference.

Family members also told us how they were involved in discussing with staff, their relative’s care and were fully involved. One relative told us before their relative’s admission, they were asked for a “Detailed history.” This was to enable care staff to understand their relative and how to care for them. This included food choices, interests and preferences.

Staff we spoke with told us about they gauged how to care for people. They told us how it was important to involve people and their relatives as it helped them understand what was important to people. Staff also told us they spent time with people upon admission to help them understand people’s needs.

When we spoke to staff about their understanding of dignity and respect, all could give clear examples of what this meant, for example, “Knocking before entering a room”. Relatives also stated that they felt that sensitive issues with their relatives were handled respectfully. One relative told us their relative, “Had some settling in issues…it was all done sensitively when staff needed to speak to us about an issue.”

People told us that that their family members visited them whenever they wished and people were supported to maintain contact with their family. One person said, “I can telephone [my relative], and [other relative] can call anytime.” Another family member said, “If we wanted to come at 9pm at night, we could do that.” Another family member told us, “My relative can call whenever they need, which is important to them.” We watched how a staff member offered reassurance to a person who had become upset and this had a positive impact on the person. This person was expecting a visitor and staff helped them to get ready for their visit and gave them and their family space and privacy.

Good

Is the service responsive?

Our findings

People and relatives we spoke to told us that they or their loved ones were involved in making decisions that affected their care. One person told us, “Sometimes I have a bath and sometimes I have a shower. I get to pick what I want.” A relative also told us, “They are good here…we’re kept informed.” People’s likes and dislikes were recorded and people’s life histories could also be found in care files so that care staff knew about people and could understand how to deliver care appropriately to them. One person told us about drinks they especially liked and about some of health directed restrictions to their diet. When we spoke to staff, they were able to confirm this person’s preferences and how they supported them. Relatives gave us examples about whether their input into delivering care was considered. One relative told us, “They asked me to come and speak to them anytime and I can go in and chat to them.” Another relative told us about their relative’s admission to the service, “We were asked about likes and dislikes.”

We asked people about their likes and dislikes and personal preferences for completing activities. We observed that efforts were being made to deliver activities based on people’s preferences. For example, during the inspection a ‘Gentleman’s Club’ was running, with people playing cards and chatting to replicate a pub atmosphere and other activities were also provided based on preferences. When we asked about how it was known who enjoyed which activities, we were told that each person had been consulted about their preferences for activities and the co-ordinator kept a record in order to determine which activities to include people in.

We saw people enjoying a gentle exercise class in another lounge. People chose to take part or decline activities. Some people slept throughout the activity whereas more able people were sat in the quiet lounge. Although a programme of activities was listed in the lounge, on the second inspection day, a day when the activity co-coordinator was not in work, people were observed sitting around in the lounge with very little planned activity taking place. The manager and operations manager reported that a further activity co-ordinator was being recruited; interviews were scheduled so that more could be done to occupy people throughout the day.

People told us that they knew how to raise concerns or complaints. One relative told us, that they had had an issue and raised this with the key worker and was resolved. They also told us the manager and staff were very accessible and that they could speak to them about anything and that often this was how they resolved low level issues. One relative explained how a staff member had provided reassurance when they had raised concerns and said “no matter how trivial, please come and talk to us to resolve it.” Complaints had been received, the provider had used feedback from people and relatives to improve their individual care needs. We saw that regular questionnaires went out to people, staff and relatives and the results of these were being analysed at the time of our inspection.

Requires improvement

Is the service well-led?

Our findings

Although people and relatives all gave us positive feedback on the service, and told us that the manager was approachable and accessible; there were inconsistencies in the way that the service was delivered.

Quality assurance processes were in place but had not identified the issues we found. Infection control audits had taken place but had not identified the issues we found. Whilst the manager and operations manager told us about audits to measure quality, such as reviewing care planning records, room/environmental audits as well as measuring staff competencies, there was a reliance on the manager reporting back to the operations manager, rather than the provider robustly evaluating the service with their own method of quality control. The provider's review of quality at the service did not demonstrate a thorough method for measuring improvements. For example, the manager told us that findings were reported back to the operations manager on a monthly basis but the manager's audits were never interrogated further.

Although people told us there were sufficiently supported by staff, we were not assured that staff were effectively deployed to deliver a high quality service. The lunch time experience for some residents was not positive, with some people leaving before they had completed their meals. Whilst others did not receive support when required. This example, together with people being not supervised for long periods in the lounge areas meant that the staff available were not able to deliver the care expected. Although we reviewed staffing rotas and saw that there were an adequate number of staff on duty, we did not feel assured that staff available were led effectively to deliver a high standard of care.

We also identified that improvements were ongoing. For example, staff told us how the new handover system was working well and ensured that the staff coming on shift were aware of any particular concerns from the staff going off duty. The service had also recently introduced a 'Clinical lead' to ensure that all Nursing issues would be overseen by one person. Although we were able to see that support was being provided by another Clinical manager from one of the provider's other services. It was not clear how the manager could be assured that the clinical team at the service were doing what they ought to or that the they were doing their job well. When the manager was asked about this, they were unable to tell us. We were not assured that the systems for delivering high quality care were yet in place.

People and relatives told us they were happy with the service, and that they found the Manager, "Very, very helpful." When we asked people if they knew who the manager was and whether they could easily approach the manager, they told us they could. We saw numerous examples of the manager chatting to people and relatives in a relaxed manner. People responded to the manager with a smile or acknowledging them.

Staff we spoke to told us that the registered manager would listen and that they could raise issues to them. Staff told us that they could either approach the manager directly or they could raise issues with their immediate line manager and were satisfied that issues would be followed through. Staff were also aware of the provider and felt they could raise issues with them also.

The manager told us about support that was being offered from the providers other service. For example, the manager was being supported to attend training and also had another manager visit the service to provide additional help. The provider was also working with the manager to ensure all jobs required by the handy man were completed. The manager told us they were benefitting from working with local district nurses to improve care, as a number of people received support from the District Nurse and this would enable people received consistent care. Whilst we noted that support was being offered to the manager to develop, we could not yet be assured that systems were in place at present for the manager or provider to understand how quality could be improved further.