Care Quality Commission

Oldfield Residential Care Ltd

Bluebrooke Residential Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 6 August 2015 and was unannounced.

The provider of Bluebrooke Residential Home is registered to provide accommodation and nursing care for up to 43 people who have nursing needs. At the time of this inspection 31 people lived at the home.

The manager was appointed in June 2015 and has made an application to be registered with us. 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.

Although people received their medicine as they should, the administration of people's medicines was not delivered within a timely way to ensure there was sufficient time between doses. The medicine round was not fully staffed which meant that it took longer than necessary for people to receive their medicines.

Summary of findings

Although people received their medicine as they should, care staff did not always know what symptoms people would display should they require extra pain relief. There could therefore be a risk that some people did not receive extra pain relief when they required it.

People lived in an environment where despite some major improvements; some areas were unpleasant. The manager had recognised that carpets needed replacing and caused an odour but these had not yet been removed.

People were cared for by staff who understood how to identify and report potential harm and abuse and who to report their concerns to. Staff told us they had received training and would speak to a manager if they were unsure of anything.

Care staff underwent a recruitment process that included background checks to ensure it was safe for staff to work with people at the service.

Care staff did not always understand the full implications of the Mental Capacity Act and what it meant to obtain people's consent. Where people received their medication hidden in food, the correct procedures had not been followed.

Care staff were supervised and received regular training. Care staff had undertaken some specialised training and understood the circumstances for when this should be used. Care staff were comfortable in raising questions about things they were unsure about.

Care staff despite working hard, did not always apply their understanding of Dementia care to the examples they faced in their day to day work. Care staff did not always provide people with reassurance and distraction when they began to show signs of anxiety.

People's care was not in response to their individual needs. People's activities and interests in some cases were supported by the activity coordinator. If people's needs were more complex, their interests were not supported as sufficient understanding of their needs was not understood by staff.

People were offered choices at mealtimes and were offered drinks throughout the day. People's meals were monitored by a nutritionist to ensure people had their nutritional needs met. People's weights were also monitored regularly to ensure people maintained a healthy weight.

People and families knew understood how to complain if they needed to although. People and their families preferred to speak to staff and discuss any issues they had directly with them.

Systems for measuring people's care were not embedded which meant that people's care was affected. Changes in management meant high quality care was not being monitored to ensure people's experience was positive.

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's medicines took a long time to administer and people's symptoms for pain relief were not always known by staff. People's health risks were understood by staff and staff understood how to protect people from abuse.

Requires improvement

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

People were cared for by staff who did not always understand how best to care for them. People's consent to accept or decline care and treatment was understood by care staff but this was not followed through in all aspects of people's care.

Requires improvement

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

People's dignity was not always protected. People liked the care staff and people had involvement in their care.

Requires improvement

Is the service responsive?
The service was not always responsive

People did not always receive care in response to their individual needs. People's families were supported to visit and maintain relationships with them. People and their families were aware of the complaints process and how this could be used.

Requires improvement

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

People's care was not always reviewed and monitored to ensure people received care of the highest standard due to numerous changes in management.

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 as well as a Pharmacist Inspector, an expert Specialist Advisor in Nursing as well as an expert by experience in Dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection took place on 6 August 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 and requested information about the service from the clinical commissioning group (CCG). They have responsibility for funding people who used the service and monitoring its quality.

During the inspection, we spoke with 11 people who lived at the home. We also spoke with six care staff, the manager, as well as the clinical lead from another service run by the provider. We also spoke to eight 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 four records about people's care, staff duty rosters, complaint files, infection control audits, sixteen medical administration records and the manager's audits about how the home was monitored.

Requires improvement

Is the service safe?

Our findings

We reviewed how people received their medicines and how these were managed. We saw some people had medicines to relieve their pain which they took only on an 'as required' basis. We spoke with some people about the availability of their medicines to meet their individual needs. One person told us, "Now and again I need some pain killers. They are good and help me". Another person said, "They give me pain killers when I need them." However, we asked staff about how they knew when one person might need their 'as required' medicine. They were unable to tell us the signs and symptoms which would indicate this person required their medicine. We also saw guidance for people's 'as required' medicines for pain relief were not in place for staff to refer to so that risks of people not receiving these consistently and safely were reduced. The information did not contain details that were specific to people so that staff knew exactly when people might require medicines. The manger told us they had worked hard to improve systems so that people's medicines would be monitored and reviewed. The most recent review took place in June 2015 and although there was evidence to demonstrate systems had been improved, all of the management systems were not embedded, in place and working effectively.

We saw the staff member responsible for supporting people with their medicines in the morning ensured each person had time to take their medicines without rushing them. However, the staff member did not finish supporting people to take their medicines until late morning so there was a risk of people not receiving their medicines as prescribed with sufficient time between each dose of medicine. People received their medicines from staff who were gave people the time they needed to take their medicines without people told us they were happy with the way staff supported them with their medicines we saw staff did not finish supporting people with their medicines until late morning. The medication round was not completed until 11:20am which did not allow people sufficient time between their doses for those receiving medication at lunch time. When this was raised with the manager, the manager reported the delay had been caused as there was currently a nursing vacancy and that once this was filled, two nurses would resume completing the medication round.

We looked at how risks to people from cross infections was reduced. We noticed there was an unpleasant smell near to people's rooms, on the first floor of the home which remained throughout the day of our inspection. When we discussed this smell with the manager they stated the carpet in this area was going to be removed but had not been removed yet. We also spoke with the staff member who was the infection prevention and control lead to consider whether their monthly checks on the environment were effective. These checks included how people were protected from the spread of infection. Despite the staff member and manager undertaking regular checks and recognising the carpet had been a problem. People living one the first floor were exposed to an environment that was not pleasant.

People told us they felt safe and they did not have concerns about their personal safety. One person said, "I feel quite safe here." People also told us they could speak to someone if they were ever concerned, one person told us, "Yes, I feel quite safe. I would speak to the manager if there was a problem". We spoke to staff to review whether they understood how to keep people safe. Staff were confident in their responses and told us about their understanding. Staff could describe to us what abuse meant and where they could report their concerns to.

We looked at how staff managed people's risks. Staff spoken with knew how to support one person who was at risk from developing sore skin. Staff had assessed this person's skin needs and action had been taken to reduce the risks to this person which included specialist equipment and monitoring of how much they drank. We saw another person was supported by staff using specialist equipment. Staff were seen to reassure this person so that they were comfortable throughout the support provided. A daily handover meeting for all staff also took place where staff met to discuss people's needs and any concerns staff needed to be aware of when supporting people to meet their needs. Staff were able to raise questions and clarify areas they required information about regarding any health risks to people so that people received consistent and safe care.

Although people told us there were not always sufficient staff available to support them should they require help, we observed a number of staff around to support people. For example, when people asked for support or called out for assistance, staff were around to step in and offer that help.

Requires improvement

Is the service safe?

Two relatives also told us that there were staff around should their relative require support. The manager and clinical lead described how staff were recruited based on occupancy and dependency levels at the service and adjusted accordingly. The manager told us she had been supported to recruit the staff that were required and that some additional nursing staff had just been appointed.

We spoke to the manager about how staff were recruited. Recruitment of staff was through a specialist agency that undertook many of the checks required to ensure care and nursing staff had the necessary checks to work at the service. Staff were then given a probationary period in which they shadowed other staff and their performance was reviewed. A member of staff we spoke also confirmed this process to us.

Requires improvement

Is the service effective?

Our findings

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. We spoke to six staff who were able to describe what obtaining a person's consent meant. Staff could describe to us their understanding of a person right and what measures were in place to protect people who were not able to make decisions for themselves.

People told us that staff spoke to them about their care before undertaking any care. However, staff were sometimes unclear of best practices involved in the administration of medicines concealed in food or drink for people that did not have the capacity to make decisions for themselves. This is called the covert administration of medicines where medicines are given to people without their consent or knowledge. We found that best interest procedures had not been followed. Best interests decisions are where people acting for the person who can not make decisions for themselves try and make a decision collectively in the person's best interests. Detailed instructions were not available to enable nursing staff to know how to give people their prescribed medicines safely for those people who took covert medication. On informing the management team we were told that they were not aware of the error and that the GP had been contacted to undertake a medicine review for the person.

Staff told us that they received training which helped them support people. For example all staff had been trained and received MAPA training (Management of Actual or Potential Aggression training). MAPA training is used to calm a situation down when a person may be showing signs of aggression. Staff told us about the how this training would be applied and in which situations they would consider this training. Staff also told us that they had received specific training in supporting people living with dementia. However we observed a number of incidents when staff did not always intervene and demonstrate their understanding of dementia care. We shared this with the manager who advised us of the action they would take to keep this under review.

Staff told us about how they learnt how to care people. Staff described a mixture of shadowing other staff as well as undertaking additional training. Staff told us they had regular supervisions and that they felt supported. Staff told us they also met as a team daily and that this helped them understand any changes in people's care. Staff told us because the manager had previously worked within the team they felt at ease to raise issues with her. For example, one staff member was observed raising a question about suggestions for diabetic puddings and alternatives that could be served to people.

People we spoke with said they enjoyed the food and were offered a choice at mealtimes. A relative we spoke with told us their family member enjoyed the food and there was always a choice. We observed people eating a variety of options for their breakfast as well as people being offered their breakfast at a time of their choosing. We also saw people being offered drinks throughout the day. People who needed thickened drinks because of difficulties with swallowing were offered these. We also saw that people who were on a diabetic diet or required support were also supported to receive food in line with the nutritional requirements.

People told us about the services they accessed in addition to the help they received from the staff. People told us they were able to receive help from the doctor, optician as well as the dentist. During our inspection we saw that the local GP visited and a number of people were able to see them. We asked the GP about people's access to their services. They reported that things had improved recently and that they were working continually with the manager to improve reporting procedures. A relative told us they had asked staff to arrange for their family member to see the dentist, and this had been arranged. People also benefitted from their care being reviewed by a nutritionist on a monthly basis so that any potential problems could be quickly escalated. For example, one person's weight had dropped and they and they had been referred to the GP to investigate this further.

Requires improvement

Is the service caring?

Our findings

People were cared for by staff who did not always demonstrate best practice when caring for people living with dementia. A person was observed at various points throughout the inspection calling out and displaying challenging behaviour. Although staff worked hard, staff did not always respond to the person and the person continued to call out. Whilst the person did not display signs of distress, staff did not always intervene to reassure the person. Whilst we spoke to six staff members about their understanding of dementia care and all staff members confirmed they had received training for dementia and understood dementia care, staff did not always demonstrate how they applied this knowledge. For example, another person was seen continually walking around the building with increased signs of agitation. Whist staff understood the person and knew what symptoms to recognise, staff were not seen to offer the right support to the person to allay some of the person's anxiety. Staff told us they understood dementia yet did not show this in their practice.

Although people told us they felt staff supported them to maintain their dignity. During the inspection an incident occurred when a person's friend was offering intimate personal care to a person in the lounge. The incident was observed by a number of other people, and staff did not intervene. Whilst no harm was either meant to or suffered by the person, the absence of invention by staff meant that staff did not always recognise how to preserve a person's dignity.

People told us their friends and relatives were able to visit them whenever they chose and we saw many examples of relatives dropping in throughout the day. One relative told us they had been particularly comforted by being able to visit their family member as regularly and as frequently as they had. Relatives were able to spend time with their family member in variety of ways. For example, some people went out for the day with relatives, some people were had their family members involved with their care and some people had lunch together with their family member.

People were cared for by staff who their individual personalities. For example, when we spoke to staff they were able to describe people at the service and their likes and dislikes. For example, staff could describe people's relatives and how often and when they were likely to visit. They also understood people's care needs and recalled knowledge of people and their individual requirements. For example, one person liked to get up late and have their breakfast in the lounge and staff knew this about the person and could recall it clearly.

People told us they liked the staff that cared for them. One person said of staff, that they were, "Very caring. They are very kind to me". Another person told us, "We have a little joke amongst ourselves. They are nice". We observed some positive examples of people engaging with care staff throughout the day. We saw people proactively engage in conversations with staff members and knew their names. We also routinely saw staff touch people's hand in an affectionate manner or bend down to people's eye level to speak to them.

Although people could not recall being involved in meetings to discuss their care, when we spoke to relatives they confirmed that meetings did take place. For example, one relative told us how their family member had lived at the home for some time and how they had regularly participated in care planning meetings. Another family member recalled asking staff for more frequent toileting and changes to their care personal care routine which was followed through. A further relative said they had been invited to meetings although they had not been able to attend all of them and that this had helped them understand how their family member was cared for. Staff we spoke to told us they talked to people to understand their likes and dislikes as well as their preferences in order to best support them. Staff then shared the information with care staff that cared for those people to ensure their preferences were known and recorded.

Requires improvement

Is the service responsive?

Our findings

People's experience of participating in care and activities that reflected their interests was not consistent. Whilst some people told us they participated in activities, people who experienced communication or mobility difficulties were less likely to have been engaged. For example, people were observed sitting for long periods of time in the lounge with little to occupy their time. People were seen sleeping, slumped in their chair or appeared withdrawn. However when the same people were engaged by staff, they responded positively. When we spoke to relatives, one relative also stated, "I do think they should take her out more often." Another relative also told us that activities offered did not take into account their family member's needs.

Whilst group activities for people did take place, people who were not able to engage or who needed individual support did not receive the support they required. We spoke to the activities co-ordinator who confirmed they had not received training in order to deliver activities for people experiencing difficulties. We also spoke to healthcare professionals who were visiting the service during the time of the inspection. They raised concerns about the about the level of activity and engagement people living at the service were given. The manager told us that a further activity co-ordinator was in the process of being recruited so that there would be more opportunities to offer people individualised activities and that training would be prioritised for the activity coordinator.

People's care was reviewed and updated. We reviewed four care records and these had been reviewed and updated based on people's improved or worsening health. For example, one care record reviewed demonstrated that whilst a person had sore skin, this had improved over time and the intensity of care had been reduced. Another record reviewed also showed that a person was changed from monthly weighing to weekly weighing because there had been concerns about the person weight. This was again reverted back to monthly weight checks when the person's health improved. Staff we spoke to could also confirm changes to people's care based on changes to their health.

People told us they understood how to complain and relatives that we spoke to told us they understood how to complain. Three relatives told us they had spoken to either the staff or the manager whenever they had had any reason to. One relative told us that staff were always willing to listen and act on changes they sought for their family member. We reviewed the complaints folder and saw that where appropriate complaints had been recorded, responded to and a copy sent to the operations manager to analyse.

Requires improvement

Is the service well-led?

Our findings

A new manager had been recruited and had recently joined the service. The manager had been the fourth manager in 12 months and had worked with senior managers to try and understand and respond to some of the issues that were affecting the service. The manager told us staff had worked hard to ensure that systems for medicine management improved. This included undertaking regular checks on people's medicine administration records to identify any problems and to ensure staff followed safe medicine procedures. We were shown evidence of the most recent reviews that took place in June 2015. These demonstrated there were some issues identified with the storage of medication and that the manager was attempting to address them. Although some practices were improving we still found that safe medicine management systems were not fully in place. In addition, the manner in which medicines rounds were being managed required improvement. The length of time taken to administer medicines meant that sufficient time was not given to people between doses.

Whilst the provider and manager had focussed on improving clinical care, many of the other wider aspects of care had been less vigorously reviewed. For example, we raised the issue that people did not always benefit from activities and stimulation that was based on best practice within dementia care, especially as a number of people lived with dementia at the service. This was reinforced by activities staff not always having the benefit of dementia training that would enable them to best support people. The manager and clinical lead agreed and stated that the service would try and address the issues.

Aspects of the environment had been improved. For example, it was noted that refurbishment of the building was taking place. However, some parts of the building were unpleasant for people to live in. When this was raised with management they were aware of the problem but a date by which the carpet should be removed still had not been identified.

The manager and provider did not have systems that ensured high quality care had been delivered. This was a breach of Regulation 17(2)(a) HSCA 2008 (Regulated Activities) Regulations 2014.

People responded positively to the change in management. Another person said, "I think the manager is available now, very nice." One person told us, "Yes, she is a good lady, usually available". One relative told us that there had been a "real difference and that the manager had made changes to make the place homely." Another relative was also positive about her and told us they had "Seen improvements". We saw the manager, leave her office and check on people and staff. Staff told us that the manager was "Hands on" and got involved.

Staff were positive about the manager and felt the most recent appointment had helped to offer the service some stability. One staff member told us, "Things were a mess before the new manager arrived, but they have changed a lot and I think the care is loads better now" Another staff member told us, "We get to talk about the job and understand why things are changing with the daily meeting that the manager runs".

The manager told us that that questionnaires were sent out annually to people and their families in order to understand how they could improve the service. This year's had not been sent out yet. Staff surveys were also sent out but these were not available to review at the time of the inspection.

The manager was supported by the clinical lead from one of the provider's other services who had become based at the service to offer some stability. A clinical lead is a person who takes responsibility for ensuring all the medical needs of people are correctly documented and carried out by other team members. The provider had also retained the support of a nutritionist to oversee people's nutritional needs on a monthly basis. We also noted during our inspection, that a number of improvements were taking place. The provider was supporting the manager by offering the support of the operations manager as well as managers from the providers other services.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The manager and provider did not have systems that ensured high quality care had been delivered.**