Tri-Care Limited

Bywater Hall

Inspection report

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Ratings

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

Overall summary

We inspected Bywater Hall Care Home on the 9 December 2014 and the visit was unannounced. Our last inspection took place in August 2013 and at that time we found the home was meeting the regulations we looked at.

Bywater Hall provides accommodation and care for up to 44 older people who may be living with dementia or other mental health conditions. The home is purpose built, set in its own gardens and there is parking available.

The home is divided over two floors. There is a large lounge and dining room on both floors for people to use with lift access. People living in the home have single en-suite rooms.

The home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. On the day of our

Summary of findings

inspection there was a new manager in post who had recently commenced their employment. This person had submitted an application to be registered and was going through the CQC registration process.

The experience of people who lived at the home was positive. People told us they felt safe living at the home, staff were kind and caring and they received good care. They told us they were aware of the complaints system. They also said they would be happy to raise any concerns they had with the staff and would be confident these would be listened to and acted upon.

However we found processes to keep people safe were inadequate. For example, there were not sufficient care workers on night duty to ensure people were safe. Also the home did not have enough domestic staff to meet the needs of people who used the service. For example, a number of bedrooms and bathrooms were not cleaned until late afternoon because they were not enough staff. This breached Regulation 22 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulation 210.

Medicines were not managed safely; we found tablets scattered in a person's bedroom and we found a tablet on the floor in the corridor. This meant people were at risk of not receiving their medicines when they needed them and at the time when they would be most effective. This is a breach of Regulation 13, (Management of medicine); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

On our visit we saw people looked well cared for. We saw staff speaking in a caring and respectful manner to people who lived in the home. Staff demonstrated that they knew people's individual characters, likes and dislikes.

The service was meeting the requirement of the Deprivation of Liberty Safeguards (DoLs) to ensure people's rights were protected.

The home met people's nutritional needs and people reported they had a good choice of food.

People reported that care was effective and they received appropriate healthcare support. We saw people were referred to relevant healthcare professionals in a timely manner.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Some aspects of the service were not safe. This meant people may experience inconsistent levels of care and support. There were not enough care workers on night duty to ensure people were safe. The home has a high number record of accidents and incidents of unwitnessed falls. Also they were not enough domestic staff to ensure the building was kept clean.

The staff we spoke with knew how to recognise and respond to allegation of possible abuse correctly and were aware of the organisations whistleblowing policy.

Is the service effective?

Requires Improvement

People told us they received appropriate healthcare support. We saw evidence which demonstrated that people who lived at the home were referred to relevant healthcare professionals, such as GPs and district nurses in a timely manner.

Some supervision had lapsed we discussed this with the new manager who showed us evidence staff supervision was booked to take place in the near future.

People's nutritional needs were being met. People told us the food was good and we saw people were provided with appropriate assistance and support to eat their meals.

Is the service caring?

Good

We observed how staff interacted with people who used the service and we saw they were kind and compassionate. It was clear from our observations that the staff knew people well.

People using the service said staff were kind and caring, treated them with dignity and respected their choices.

People were involved in making decisions about their care and staff took account of their individual needs and preferences. However, people's likes and dislikes were not recorded in their care plans.

When we looked around the home we saw people's bedrooms had been personalised and contained personal items such as family photographs.

The staff we spoke with told us they thought they provided people who lived at the home with good care. People living at the home seemed pleased to see staff members.

Summary of findings

Is the service responsive?

Requires Improvement

The home has an activities co-ordinator. However we were told by a member of staff, “The activities plan is not always followed and I don’t think it is well adapted for our residents.”

People’s health, care and support needs were assessed and individual choices and preferences were discussed with people who used the service and/or a relative or advocate. We saw people’s plans had been updated regularly and when there were any changes in their care and support needs.

People who used the service told us their complaints were effectively dealt with and they felt comfortable to raise any concerns with management.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. The manager had not been registered with CQC.

There were some effective systems for monitoring quality of the service in place. However, these were not always dated.

Bywater Hall

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 the 9 December 2014 and was unannounced. At the time of the inspection there were 30 people living in the home. We used a number of different methods to help us understand the experiences of people who used the service.

During our visit we spoke with 11 people living at the home, five relatives, five members of staff and the manager. We spent some time observing care in the lounge and dining room areas to help us understand the experience of people living in the home. We looked at some areas of the home including people's bedrooms, communal bathrooms and lounge areas. We spent some time looking at documents and records that related to peoples care and the management of the home such as training records and policies and procedures.

The inspection team consisted of two inspectors and an expert by experience with expertise in caring for older adults. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed all the information we held about the home and contacted the local authority commissioning service and Healthwatch.

Inadequate

Is the service safe?

Our findings

We found the service was not safe. We observed the senior carer carrying out medication rounds at breakfast and again at lunchtime. The staff member took time to explain to residents what their medicine was for and offered them a choice of drink to help them swallow their medication. People were given time to take their medicine. Assistance was offered and provided when required. People were seen to be happy to accept their medicines from the senior carer. One person said, "I get my tablets on time and I'm able to take them ok."

However we did observe three tablets scattered randomly on a resident's unmade bed at 10:40am and at lunchtime we found a tablet on the floor in the corridor. This was drawn to the attention of the manager who immediately had discussions with staff. The staff member could not explain our findings. This told us staff were not ensuring people were taking their medication thus putting them at risk.

This breached Regulation 13 (Management of medicines) of The Health and Social Care Act 2008 (Regulated Activities) Regulation 210. You can see what action we told the provider to take at the back of the full version of the report.

Medicines for Bywater Hall were all stored in the medicines room located on the first floor. The room was secure with entry via keypad system; the door was kept closed at all times except when a member of staff was in the room. Both medicine trollies were locked and were secured to the wall when not in use.

The temperature within the medicines room was recorded daily and these recordings retained in a folder, filed in month order. The temperature had been recorded every day throughout 2014 with the exception of 9 and 24 April where there was no recording.

The temperature of the medicines fridge was recorded daily. The record also indicated when the fridge had been cleaned. The records were stored in month order in a folder.

The Controlled Drug (CD) register was checked and we found all entries had been signed by two members of staff. There was evidence of stock check balances being recorded; indication of quantities of CDs received from pharmacy. The quantities recorded in the CD register tallied with the amounts of CDs in the CD cupboard. There was CD medications within the CD cupboards which belonged to a person who had used the service but who had recently passed away. The senior carer told us that this had happened less than seven days previously and that following seven days these would be returned to pharmacy as per guidelines.

In the medicines room there was information and guidance for staff, for example; The Handling of Medicines in Social Care guidelines; RCN Sharps Safety; Patient Information Leaflets; guidance on CD classifications; Infection Prevention & Control guidance.

The medicines room was neat, tidy and well organised with all files easily accessible to staff when required. Care Plans for the people living on the first floor were also stored on shelves in this room.

There was no facility for hand washing/washing of medicine pots in this room. There was, however, alcohol gel/rub for use by staff.

Medicine trollies were seen to be clean, neat and tidy; Medicines were dispensed via blister packs received from pharmacy. Bottled and boxed medication had appropriate labelling on boxes and bottles; the dates medicines were opened was recorded.

The service is currently using electronic MAR (EMAR) in addition to paper MAR charts. Staff told us they were currently using both methods as the electronic version had only recently been introduced, and staff were still getting used to using the system. In addition, staff told us that the wireless reception was unreliable in some areas within the home, and they were using the paper charts as a safeguard to ensure everything was completed accurately.

MAR charts checked were seen to be completed fully with no gaps evidenced. Any special instructions were highlighted on the MAR charts. Charts were completed on the reverse when medicines prescribed to be administered as and when required (PRN) were administered or refused and the associated reason.

There were a small number of hand written MAR charts; these had been countersigned by another staff member.

There was evidence of anticoagulant therapy charts and blood pressure (BP) monitoring charts in the MAR chart folders.

Inadequate

Is the service safe?

We looked at the recruitment records for four staff and saw evidence which showed recruitment practices were robust. Each staff member had been checked with the Disclosure and Barring Service (DBS) before they started work at the home. The DBS helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable groups. Each records showed details of the person's application, interview and references which had been sought.

We looked at the staffing levels in place for care at night and domestic staff throughout the home. We were told by staff and the manager that two staff members was based on each floor throughout the night. Staff told us during this period staff were having to leave people unsupervised to assist with helping people who required two staff to support them. Our records showed the home had a high number of accidents and incidents recorded of unwitnessed falls. Staff told us people did not always sleep throughout the night and their behaviour could become increasingly challenging. This meant people were not safe because staffing levels were not sufficient to meet their needs.

This breached Regulation 22 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulation 210. You can see what action we told the provider to take at the back of the full version of the report.

The home did not have enough domestic staff to meet the needs of people who used the service. We saw a number of bedrooms and bathrooms were not cleaned until late afternoon. One of the bedrooms we visited at 10 .40 am, had a very strong smell of urine, there was a used incontinence pad by the window on the floor and the bathroom floor and toilet bowl were dirty. The duvet cover was soiled. When we returned three hours later the bed was made with a clean duvet cover, the pad had gone, the odour had diminished, but the bathroom and bedroom floor had not been cleaned.

We saw the dining room had not been cleaned after breakfast before people had started their lunch. A number of areas throughout the home were showing signs that they required cleaning.

We found downstairs the communal areas were plainly decorated with little wall decoration. There was quite a strong urine odour in the communal areas and some of the bedrooms downstairs. The staff and visitors toilet floor was dirty, the bin overflowing and the walls grubby.

In contrast, upstairs the décor was fresh and bright with coloured doors and handrails with a lot of varied memorabilia on the walls. The environment was in keeping with good dementia care.

We spoke with the manager regarding the domestic staffing levels and they agreed that more staff were needed to protect people from the risk of infection because of cleanliness.

This is a breach of Regulation 22 (Staffing), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the provider had failed to maintain appropriate staffing levels. You can see what action we told the provider to take at the back of the full version of the report.

The home had policies and procedures for safeguarding adults and we saw the safeguarding policies were available and accessible to members of staff. The staff we spoke with told us they were aware of the contact numbers for the local safeguarding authority to make referrals or to obtain advice. This helped ensure staff had the necessary knowledge and information to make sure people were protected from abuse.

We saw written evidence the manager had notified the local authority and the Care Quality Commission (CQC) of safeguarding incidents. The manager had taken immediate action when incidents occurred in order to protect people and minimise the risk of further incidents.

The staff we spoke with told us they were aware of how to detect signs of abuse. They were aware of the whistle blowing policy and felt able to raise any concerns with the manager knowing they would be taken seriously. These safety measures meant the likelihood of abuse occurring or going unnoticed were reduced.

A carer worker told us they thought the in-house training was of good quality.

Staff told us they have a good informed handover every morning and evening.

Inadequate

Is the service safe?

One care worker expressed concern over the newly introduced 12hr shifts. They felt they shouldn't be compulsory and were too long.

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. No Deprivation of Liberty Safeguard applications were seen in the care plans. The manager confirmed that no applications had been made for any anyone in the home.

We looked at seven care plans. Of these four of the people had a confirmed diagnosis of dementia. In their care plans, there were Mental Capacity Assessments which had been carried out in October of this year, in respect of various aspects of care needs. There was evidence of Power of Attorney contained within these care plans and consent had been signed by the appointee on behalf of these people.

In one care plan, there was a Best Interests decision documented in respect of administering medication covertly. This was entered and signed by the GP and reviewed by staff on a monthly basis.

All risk assessments were seen to be in place, relevant and up to date. Although the assessments were generic, these were personalised to reflect the individual. Life histories was completed in five of the seven plans we looked at.

There was evidence of input from health professionals documented in the care plans. Care plans showed people were routinely referred to community health professionals such as community nurses and doctors. The outcome of these visits was documented to assist care staff in meeting peoples' needs. This showed people received additional support when required for meeting their care and treatment needs.

We spoke with a district nurse who was visiting four people on the day of inspection. They said "The staff were very helpful and I can talk to them OK." They commented that they thought the home's staff could do with more training and more staff, she said "Once or twice I've thought we should have been called earlier and I would say so to the staff."

We noted one person had insulin injections twice every day given by the district nurse. We asked one of the carers about this. We were told by the member of staff they do not test the person blood sugars in the home, only the district nurses do this. If the staff thought the person was having a hypo glycaemic attack they would call an ambulance. We noticed there were some information leaflets about managing diabetes on a notice board by the front door. The care worker was vague about exactly what would happen regarding initial management of a possible hypo glycaemic attack.

People who lived at the home and their relatives spoke highly of this home regarding effectiveness. One person told us "They take me to hospital if I've needed to go."

A relative said "If an outside professional is required e.g falls team after a series of falls it takes a long time for anything to happen, but it's not the homes fault."

A carer worker told us that a person who used the service received a walking frame recently as a result of a falls assessment which was instigated when it was observed they were having difficulties getting on and off the toilet and it were causing hygiene issues. This was all documented in their file and the falls assessment was arranged from there.

We looked at records which showed staff at the home received training which ensured they had the necessary skills to perform their roles. We saw the staff had attended annual training considered to be mandatory for example, safeguarding adults, dementia awareness, food hygiene, emergency first aid, fire, health and safety/COSSH and infection control. We did note staff had attended a number of these training courses on the same day. Staff told us they had difficulty absorbing so much information in one day.

A programme of annual appraisals was in place to provide staff with support. However staff had not received regular individual supervision of their work which could enable them to express any views about the service in a private and formal manner. The manager was aware of this and people booked in for the weeks to come.

People we spoke with spoke positively about the food at the home. They told us "We get well fed." "The food is alright." People said there are always at least two choices of main dishes for lunch. We saw care workers adapted meals for people to help them to be independent, for example a person who used the service who was blind was given finger food which enabled them to eat without assistance. The staff were aware that they had to offer her food more

regularly throughout the day to ensure sufficient intake. Another person required softened food and that was also addressed. If people wanted to have lunch in the lounge or their rooms they were given the choice to do so.

The dining tables were laid with bright checked table clothes. Two people in wheelchairs were placed together and they were wearing clothing protection. We did not hear them being asked permission to have the protection garments put on or taken off. The food looked appetising although we saw meals were brought to people already plated which meant people had no choice in the components of the meal or portion size. Some people could eat their meals themselves adequately and their food was served on bright green china plates with a wide rim on one side. This helped people with dementia and those with other disability.

We spoke with the cook who told us people could choose what they wanted to eat and if someone did not want what was on the menu they were offered an alternative. We observed one person asking for a different meal to what was on the menu and being given what they had asked for.

Good

Is the service caring?

Our findings

Members of staff spoken with told us they provided people who lived at the home with good care and they had a good staff team. Staff were able to tell us how individuals preferred their care and support to be delivered. They also explained how they maintained people's dignity, privacy and independence. They told us about the importance of knocking on doors before entering people's bedroom and making sure curtains were closed when supporting people with personal care. We noted that this was routine during our observations on the day of the inspection. This demonstrated the staff had a clear knowledge of the importance of dignity and respect when supporting people.

We saw people looked well dressed and cared for. For example, people were wearing jewellery, had their hair styled and the men shaven. This indicated to us that staff had taken the time to support people with personal care in a way which would promote their dignity.

The home was considered by people living there and their relatives as caring. Typical quotes include "Staff are friendly. I'm happy with them all." "The staff are kind and gentle." "It's wonderful here. I'm so well looked after. I really am." One person who had been living at the home for long time did say, "It's a rushed job with everything and the more fuss you make the worse it is. I ring to go to the loo but get caught short sometimes."

One person told us he was happy with the way the staff helped him in the shower. "It felt safe and my dignity and privacy was maintained."

One person visiting and their relative said they thought that people's independence was promoted by the staff. The visitor told us they were always made to feel welcome by staff and could visit at any time.

All the visitors we spoke with reported involvement in their care plans of their relatives and had regular review of the plans with the staff. A new person to the home told us they liked being given their independence "I was involved in my care plan with my son. They know my tastes. They allow me to be in my room, no one comes in. I can close the door and control my space."

Requires Improvement

Is the service responsive?

Our findings

People's records provided evidence that their needs were assessed prior to admission to the home. This information was then used to complete more detailed assessments which provided staff with information to deliver appropriate, responsive care.

One relative told us the standard of care was good. The person said, "If there are any concerns the staff are in contact straight away e.g when my mum fell." "The problem is mum is so independent she won't use a frame which makes things a bit difficult for the staff." "We have monthly meetings and can bring up anything and it will be acted on."

Another relative was impressed with the action of the home. They said they had been concerned that their mum was not changing her clothes enough. "I mentioned it to the staff and a carer worked with me to show me how to help my mum to be more accepting of support."

We asked people about how they spend their time in the home. These are some of their response: "I've got a kindle and puzzles. I can go out if I want. I feel happy" "Mum doesn't like to join in things though I know there are joint activities in the Lodge next door most days" "I'm happiest with my books from the lending library, a service that comes to the home" "I've made friends with a couple of other residents. They join me in my room sometimes to chat which I like."

A staff member told us she was generally happy working at the home, but had concern about the lack of stimulation for people. They said, "There is a new minibus but no excursions arranged yet." We were told by staff, "The activities plan is not always followed and I don't think it is well adapted for our residents."

We spoke with the recently appointed activity co-ordinator who told us they worked with a colleague from the sister home next door. They told us they had no previous experience as an activity co-ordinator for the elderly but was spending time having some training from the manager which they found helpful. We saw they had introduced a newsletter and displayed a monthly program of activities on the notice board. They told us they thought the budget was extremely tight at £150.00 per month for resources.

We looked at the concerns and complaints records. Complaints were recorded and it was clear how the provider had responded to them and what action was taken. This included meeting with families and giving staff feedback on issues to prevent re-occurrence in the future.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the home did not have a registered manager. The registered manager had left the organisation in April 2014. Since April 2014 the home had been managed by two managers. The current manager had been in post since the end of July 2014. They told us they were going to submit a manager application to register with the Care Quality Commission. At the time of writing this report the application had been received and was being processed.

We looked at how the home gathered the views and opinions of people who lived at the home and their relatives, and how they used the information to improve the quality of the service. We were shown surveys which had been completed by people and their relatives. We found the comments were positive and complimentary of the staff. However, these were not dated so we were not able to evidence when they were done.

We found the provider conducted several audits of the service, for example, residents monthly weights, skin tear monitoring, bed rails, medication, pressure ulcers, complaints, falls management, accident statistics along with the monitoring of accidents, incidents and near misses. We saw issues were identified and action plan were completed with dates of when action had been completed.

Resident and staff meetings were in place, which were an opportunity for staff and people to feedback on the quality of the service. Staff and residents both spoke positively about these meetings and said management listened to and acted on their comments.

We spoke to five staff members who seemed well motivated. Some had worked at the home for several years. Everyone we spoke with was happy with the management style of the home. They found the manager approachable and one care worker liked the way the service encouraged staff to become more qualified and take on more responsibility. One care worker told us “I take any ideas I have to the office and I don’t feel ignored for example I suggested we could do with a furniture makeover to cheer the environment up.”

There was a clipboard with various charts attached, including: Weekly Infection Control – Bed Changes Chart; Falls Prevention Information; Handover Communication Sheets; Daily Handover Report – Passing the Baton; MAR Chart Daily Check Sheets – these were being used by staff throughout the day.

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 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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The provider had failed to protect people against risk associated with not maintaining appropriate staffing levels.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration of medicines.**