Bethany Lodge Kent Limited

Bethany Lodge

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place over two days on 29 and 30 March 2016 and was unannounced. The service was previously inspected in August 2014 and no breaches in the legal requirements were found.
Bethany Lodge is a purpose built service on ground level providing accommodation, nursing and personal care for up to 24 adults with complex physical disabilities, including acquired brain injury, and congenital and degenerative conditions. There are two lounges, a dining room, and separate visiting or entertainment area and separate toilets and showers or bathrooms. All bedrooms are single with specialist beds and hoisting tracks; the more recent extension has slightly larger rooms. There is a spacious arts and crafts room in the grounds. All areas are wheelchair accessible. A hydrotherapy pool is available for people's use at a partner service nearby.
At the time of inspection there were 24 people living in the service. The age range of people varied from younger adults to people who were older. Care and support was provided by a matron (who is a registered nurse) and a team of nurses and care assistants supported by the daily presence of the provider. The provider was also the current registered manager though the matron had applied 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 2008 and associated Regulations about how the service is run. Both the provider and the matron supported our inspection visit.

Staff knew people well and understood their needs, choices and preferences. Personalised detail was absent from some care plans which meant that peoples' preferences about their care may not be known and carried out.

Medicines were stored safely, and administered by trained nurses, however for people who wished to self-administer medicines there was no protocol in place to ensure that they were assessed as safe to do so.

People were offered a choice of food at mealtimes. People's intake of food and drink was monitored but records did not accurately reflect how much fluid people were drinking or if the amounts taken were sufficient to maintain people's health.

People were thoroughly assessed prior to admission and a plan of care created to ensure all their needs were met. Life histories were obtained so staff could apply this knowledge to the care of people. The interaction between staff and people was compassionate and understanding. People and their relatives had confidence in staff to respond to their needs, and listen to any concerns they had. Family members were made welcome so they could be involved in people's care.

All staff had received training in the Mental Capacity Act 2005 (MCA) and staff understood the principles of the Act and how to apply them. Where people lacked the mental capacity to make decisions the home was guided by the principles of the MCA to ensure any decisions were made in the person's best interests.
CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS

applications had been made for people who lived in the home to ensure that people were not deprived of their liberty unnecessarily. Staff had received training in adult safeguarding and knew how to follow the home's safeguarding policy in order to help people keep safe.
Checks were carried out on all staff to ensure that they were fit for employment. Systems were in place to ensure that new staff were recruited and trained to deliver the safest possible care. Staff said they were supported within the team, knew how to perform their roles safely and were given regular training and supervision by the management team. There were opportunities for staff to develop and refresh their skills. There were sufficient numbers of staff available to meet people's needs without being rushed.

An arts and crafts tutor provided the popular activity of art therapy, which also helped form links between people and the local community. Other activities and entertainments were provided, including trips out to places like pubs and bowling. Peoples' views on what they would like to do was actively sought and their ideas taken up by the management team. Complaints about the service were acted on and responded to appropriately.

The service was clean and staff knew what action to take to minimise the spread of infection. People's rooms were personalised and furnished with their own things. The rooms reflected people's personalities and individual tastes. Checks were regularly carried out to ensure the premises and equipment used were safe. Fire detection and alarm systems were maintained and staff knew what to do in the event of emergency to protect people.
Any medical problems arising in people were referred promptly to the relevant healthcare professional. The service was currently developing ways to improve their partnership with the local medical practice to ensure continuity of care out of hours.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People received their medicines when they needed them but some areas of medicine administration needed improving.

People were protected from harm and from abuse by staff with the appropriate skills and understanding.

There were sufficient numbers of staff on duty to make sure people received the care and support they needed.

Is the service effective?

Requires Improvement

The service was not always effective.

People with specific fluid intake needs were not monitored efficiently.

The service responded quickly to people's healthcare needs.

The training and development of staff was reflected in their practice.

People were given a choice of nutritious meals.

Is the service caring?

Good

The service was caring.

People were supported by staff that were respectful and understood their needs, choices, and life histories.

People were treated with dignity and respect.

People were involved in making decisions about their care and support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that was personalised in a way that accurately represented their needs.

People had their wishes and preferences identified and were encouraged to pursue their interests.

People said they would be listened to and their problems dealt with quickly.

Is the service well-led?

Requires Improvement 

The service was not consistently well led.

Feedback about quality monitoring was not available to those who had contributed their views.

There was a lack of analysis of audits to ensure that service delivery continued to improve.

The management team set high standards, were visible within the service and supported and encouraged good practice.

The service sought to improve its partnership with other agencies to improve peoples' experience of care.

Bethany Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 and 30 March 2016 and was unannounced. Two inspectors and a specialist nurse adviser undertook the inspection. The specialist advisor had clinical experience and knowledge of people with learning disabilities and acquired brain injuries.

The provider had not been asked to provide a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to inspection we looked at previous inspection reports and notifications about important events that had taken place at the service. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection we looked at records related to health and safety, nutrition and hydration, medication, recruitment, and training. We examined four staff recruitment files and four care plans and at documents such as staff rotas, meeting records, quality assurance questionnaires, complaints and monthly audits.

We spoke to two people who use the service, three relatives, two healthcare professionals and five members of staff in addition to the owner and the matron.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the service and relatives confirmed this. One relative told us that she felt she could leave her son without fears for his safety. Another told us that whenever they visit they ask if their relative is happy and are always told "yes".

People's medicines were not always managed safely. There was one person self-administering their own medicine. Another person had been assessed as unable to safely self-administer. There was no protocol in place to support this assessment process by providing clear guidance on what was safe or unsafe for people who wished to do this. There was a risk that staff supporting the person to self-administer would not be aware of ways in which this may be unsafe.

The provider had insufficient policies and procedures to address the administration of medicines.
This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were safely stored and handled and the records kept for controlled drugs were accurate and up to date. People could be identified in their medicines records by their photographs and information was present with the medication administration records (MAR) that indicated how people chose or needed to receive their medicines. Only registered nurses administered medicines to people and this was observed being done in a safe way. People who were diabetic had their own separate blood monitoring equipment and were reviewed regularly by the diabetes specialist nurse. People received medicines in a variety of different ways according to assessment of their needs. For some this was via percutaneous epigastric tubes (PEG). This was performed by the nurses on a daily basis although tube care was overseen by a specialist community team. We saw that a person was asked their choice about how to take their medicine, the nurse referred to the MAR sheet to check the medicine was correct and given to the right person and a drink was offered with it.

People were kept safe by regular and up to date health and safety checks and audits of the environment. The control of hazardous chemicals (COSHH) legislation was in place to reduce risk to people, staff and visitors. Staff fire drills were documented and people had personal evacuation plans in place (PEEPS) that were current and documented the specific ways people would be supported to be evacuated by staff in an emergency. Risk assessments were in place regarding people's assessed needs including being transferred in wheelchairs, and going out in the minibus.

Recruitment files showed that new staff were recruited by undergoing the appropriate checks in background and employment to ensure they were suitable to look after people. There were sufficient staff on duty to provide care for people without rushing. There were nine staff on duty on the day of inspection; three registered nurses and six care staff. They were supported by a cook, physiotherapy assistant, three domestic staff, and a handyman. Care staff said this number was ideal. Staff covered for sickness or if agency staff were used the matron told us she tries to get the same agency employee to help provide continuity of care for people. Each shift was led by a registered nurse and overnight there were three waking staff, one of which

was a registered nurse.

People were supported by staff that knew their histories and understood their needs. Staff showed understanding of individuals who may display behaviour that might harm themselves or others, and how to de-escalate this. There were current safeguarding and whistleblowing policies in place, accessible to staff. Staff understood what safeguarding meant, how to report it and where the current contact details for the local authority safeguarding team were displayed. They told us they would have no hesitation in reporting any concerns to the senior management team or the Care Quality Commission. Staff were trained in adult safeguarding on recruitment and attended refresher training annually. They could access DVD training at any time to complement this.

The property was well maintained and warm. The atmosphere was calm and welcoming and the interior of the service was clean and bright .There was a supply of personal protective equipment for staff (aprons, gloves etc.) in bathrooms and accessible in the corridors to help reduce the spread of infection.

Requires Improvement

Is the service effective?

Our findings

Staff told us that they were quick to respond when peoples' health needs changed and this was confirmed by a visiting nurse practitioner who said that they have seen "only good care" in the service. A relative told us that he had "no concerns whatsoever with the care" and said "I am so pleased (my relative) is living there". Another member of the multi-disciplinary healthcare team told us that they had good communication with the service, that the staff were always prepared for their visits and if people required additional care and treatment "they were on it as best they can". A care assistant told us they follow the persons' care plan and stressed the importance of 'knowing your service user well'.

Drinks were offered to people after and between meals but there was no reliable record to show people were drinking adequate amounts of fluid. We noted that a book was completed with a tick when people had been offered a drink. We were told that this helped staff not to miss any one out of having a drink. However this tick did not state how much was offered, if it was drunk, or how much drink was taken, so the value of that record was minimal. One person's care plan stated 'to maintain hydration and observe urine output' were assessed needs but their specific fluid requirements were not stated so it was unclear if staff would know what 'maintain hydration' meant, and the recording of the fluids for this person was inconsistent. Another person ate very little and their care plan stated 'ensure an adequate intake of fluids and good level of nutrition' but there was no consistent monitoring of the calorific intake or fluid balance in place to demonstrate that these needs were being met. People were therefore at risk of dehydration because their fluid needs were not being met.

The provider was not ensuring care and treatment was provided in a safe way for people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were offered, and received, a balanced, healthy diet and ate what they wanted, when they wanted it. One person asked for toast between meals and this was responded to straight away with staff asking what preserves they would like with it. People were assisted to tables in the dining room to await their lunch, most remaining in their specialised chairs. Consent was gained from people before their aprons were put on to protect their clothes. The dining room was bright and airy. There was a written menu showing the daily choices on offer on the wall in the foyer. Staff took meals to individuals and sat with those who needed assistance. This was done sensitively, giving people time to finish their mouthfuls and chatting in between. There was a lot of smiling and interaction between staff and people. A person was asked how the food tasted and gave the "thumbs up" sign. Where a person had the ability to eat and drink unaided this was supported and encouraged. For people with special requirements such as percutaneous epigastric feeding tubes, for those losing weight, or to prevent weight gain a malnutrition universal screening tool 'MUST' was used. This includes management guidelines which can be used to develop a care plan. Records showed that where this tool was used people were referred to the appropriate nutrition specialists or the speech and language therapist and that guidance received from them was followed.

The Mental Capacity Act 2005 (MCA) ensures the rights of people who lack mental capacity are protected

when making particular decisions. The MCA provides the legal framework to assist in decision making with those who 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. Any decisions made on behalf of a person lacking capacity must be in their best interest and the least restrictive possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the
MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff completed training about MCA and DoLS and records showed that decisions made on behalf of people were made in their best interests, involving the appropriate people. Some people had DoLS authorisations, others had been applied for. Two care plans contained Do Not Attempt Resuscitation requests (DNARs) and these had been made with the person's advocates, family and health professionals. Consent was sought from people before staff supported them with treatment or personal care.

Staff said they were supported within the team and knew how to perform their roles safely. New staff followed an induction process, completed statutory training and shadowed an experienced member of staff for 2-3 weeks. Records showed that established staff had completed common induction standards and were up to date with mandatory training. Senior care staff and registered nurses supported new staff to attain the Care Certificate. The Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. There were training opportunities scheduled for all staff to develop and refresh their skills, for example training in safeguarding vulnerable adults. A training plan showed upcoming plans for staff to train in venepuncture (taking blood), medicines, the MCA and DoLS. Staff worked on the Qualifications and Credit Framework (QCF) level two and above in health and social care. To achieve a QCF, staff must prove that they have the ability and competence to carry out their job to the required standard. The provider had invested in one member of staff to become the moving and handling trainer for staff within the service which meant that refresher training on this could be provided in-house and that practice in transferring people within the service could be regularly monitored and improved.

A supervision system was in place for staff both individually and in groups. The matron provided frequent sessions on training issues and staff could also access DVD's and other learning resources for subjects such as infection control, death, dying and bereavement and many others. The registered manager completed annual appraisals and formal supervisions where training and development needs were identified and acted on so that staff were competent to deliver safe and effective care and treatment for people.

Records showed that people were supported with their day to day care needs from a wide variety of sources such as nurse practitioners, doctor, opticians, dentists, physiotherapists, and chiropodists. Documents and our observation showed that a person's needs had increased overnight. This was spotted early by staff and the person referred for medical support as soon as possible. This resulted in the person being seen by a doctor and admitted to hospital for treatment without delay. A healthcare professional told us that the medical centre are asked promptly when there is a need to support people with care and treatment such as taking blood for tests, and obtaining prescriptions. The treatment for one person involved support to prevent the development of pressure ulcers. The care plan was clear as to the support needed, including having an air mattress and being regularly turned in bed. Charts showed that these measures were in place. The relatives of two people who use the service confirmed to us that any support needed was identified quickly and that they were very happy with the care their relatives received.

Good

Is the service caring?

Our findings

A member of staff told us that they encouraged independence in people by supporting people to do as much as possible themselves. Another told us "we are not here to provide a 'service'- we are here to provide them with a life and a home". Relatives told us that they were kept informed of changes in their relatives' wellbeing and given updates about their care. One said of the care, "Very good. Like a family" and that they were also made welcome when they visited.

We observed kind and caring actions and words from staff when they interacted with people. Staff used smiling, appropriate touch, tone of voice and body language when communicating and used people's preferred names. They waited for responses from people who took longer to communicate. Tasks were not rushed. We saw that the registered manager and matron were well known to people and that they also stopped to interact with people as they met them. During lunch a carer was unsure how to support a person to hold their own cup to have a drink. They asked another staff member so the person could be supported to drink independently. Observation highlighted how people interacted with staff also. For example when a treatment task was due for two people, they greeted and responded happily to the nurse who went to assist them. As inspectors walked around the service they were introduced to people by the staff. We observed staff taking care to protect people's dignity such as helping keep people clean while eating in a dignified way, by discreetly wiping cheeks and chins between mouthfuls. A person's feet were placed on the foot plates of their wheelchair before moving, and people were reassured when staff administered medicines.

Staff told us that life histories were sought from the person and their relatives on admission and as a result staff knew the people well. A keyworker was allocated to every person. Their task was to liaise between the person, their relatives, carers, and the multidisciplinary health professionals, and also assisted with shopping and activities. People were involved in how their rooms were decorated and could express themselves by having personal possessions around them such as football team scarves, posters and pictures in their rooms. People went with relatives whenever they wished and sometimes spent periods of time away from the service. Some people had telephones in their rooms so they could contact family or friends at any time.

People were involved in making decisions about their care and treatment. People and their family or carers were invited to discuss their care needs and preferences together with the management team when necessary or when they requested it. Relatives and documents confirmed this. One person and their relative had sat down together with staff to discuss the decision over having a feeding tube. Other people had family and other healthcare professionals support them in making decisions about resuscitation and recording this on the care plan and the 'do not resuscitate' (DNAR) form. Information which would help people to be involved in their own care planning was not made available to people in a way that they could understand, such as easy-read text, pictures or technological aids. This is an area for improvement. Some people were able to communicate their needs to staff. We saw a person who had a percutaneous endoscopic gastrostomy (PEG) tube in place approach staff to prompt them to perform a washout of the tube, indicating they were expecting it, ready and waiting.
When a nurse spoke to a person in the lounge about having their medicine the person wanted to continue

watching TV, so they were moved a discreet distance away from others for the medicine, still able to watch TV, before re-joining the group. We saw medicine delivered via a tube for a person. Even though the person clearly understood the process and was ready and waiting for it to be done, as it was routine for them, their consent was sought by the nurse prior to beginning the procedure.

Requires Improvement

Is the service responsive?

Our findings

Before admission people were assessed by the matron or the registered manager to ensure their needs could be met. People could also experience a trial stay of up to three months at the service prior to committing to live there permanently. Plans for the care of the person were created as a result. These care plans for people were not always personalised. They contained analysis of risk, and lists of treatment and care requirements but lacked detail that would ensure the care given reflected the person's choices. In one person's care plan their pressure care needs were clearly described, but their turning and positioning needs were not detailed. This meant they may not be re-positioned in the bed frequently enough, nor in the right way to prevent pressure sores developing. People who had epilepsy had charts that detailed the frequency and duration of seizures but no detail on how staff should respond to the individual's seizure, such as how to support them or how long to wait before referring the person for medical supervision.

The provider was not doing everything reasonably practicable to make sure that people received person-centred care and treatment. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other records did reflect personalised needs in detail, such as the pressure area care and medication support that one person required. Charts indicated they were assisted to sit out of bed for regular periods, as directed by specialist nurses. A relative confirmed that this was happening. All people with feeding tubes had care plans in place.

There was a choice of activities daily, and a program of events showed days out, pub lunches, bowling, and visits to animal centres. On the day of inspection there was an Easter bingo session which was well attended by people. The arts and crafts room was well used, and a professional arts and crafts tutor was present four days a week. People who attended could engage in art projects according to their strengths and abilities by using different materials and techniques. The tutor had detailed information about people so that they could be fully supported to participate in the activity. Various crafts reflected people's interests; one person who enjoyed science-fiction was creating a themed picture for their room and a person who was visually impaired participated using textured materials. Another person was being supported to create an Easter bonnet. Artwork was displayed on walls and doors around the building for all the people to enjoy. People in the group had helped create props for local Nativity plays and had also entered a community art competition and won a prize, so this facility was also assisting with fostering links with the local community.

Notices on the main noticeboard showed that people attended residents meetings. Topics discussed included activities to consider and what pubs were requested for lunch visits, the possibility of opening a shop, holidays and arts and craft projects. Plans for the shop were under way. Staff told us they acted on suggestions from people but there were no records to confirm this. This is an area requiring improvement. Compliments to the service were noted, with people being complimentary about the care given to people. There was a visible and easy-read complaints policy available to people on the noticeboard. There were no current complaints but historic records showed complaints were dealt with in line with the company policy. One example of a complaint from a relative was seen in the file. It concerned how staff should improve on a

particular aspect of the personal hygiene routine for a person. Matron had responded and amendments were made to the care plan. We were able to speak with the relative, who confirmed that care had improved.

Requires Improvement

Is the service well-led?

Our findings

A staff member told us that the management team were "supportive, very good". Another said "Teamwork here is really good. We help each other". A visiting nurse told us staff at the service were knowledgeable and worked co-operatively with the multi-disciplinary team of healthcare professionals. Relatives told us they found the registered manager and staff approachable and would not hesitate in raising concerns with them if they felt this was necessary. One relative told us they felt that the service was constantly improving.

A suggestions box was present for anyone connected with the service to put their suggestions in and news about the service was sent to people and relatives in a newsletter every few months.
A notice had been put up in the foyer to thank relatives and visitors for their recent feedback in a questionnaire that included "Staff are very kind, friendly and considerate." Compliments were collected in a file for people to read. However there was no record of actions taken as a result of the feedback, to drive improvements in service delivery. There were some systems in place to monitor the quality of the service people received, such as audits of all health and safety checks. Accidents and falls were recorded but an audit on these was performed by an outside contractor. Although these audit results were kept no evidence of analysis to ensure the incidence of accidents would be reduced.

There were no effective systems in place to assess and monitor service quality. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Audits on medicines management had recently identified gaps in a Medication Administration Records (MAR). Action was taken promptly to correct this with the nurse concerned given additional training in administering medicines so that people received their medicines safely.

The aim of the organisation was to offer a home for life offering dignity, respect and safety and staff we spoke with confirmed this was what they hoped to achieve as a team. There was continuous oversight provided by the registered manager and the matron. The registered manager was visible and active in the service several times a week, had an office there and was approachable to staff. The matron told us her "door was always open to staff to discuss any issues" and staff confirmed this. Policies and procedures were current and accessible to staff to show how all facets of the service operated. The provider and registered manager confirmed that these were all reviewed annually.

The matron was established, had been in post many years, and was in the process of applying to be the registered manager; a position she had held previously prior to service re-organisation. There was no deputy manager but the matron was supported on most days by the registered manager (who was also the provider) and by an administrator at the nearby sister service. The matron could also work jointly with the manager of the sister service if additional support was required. The registered manager was approachable and present in the service most days so they were familiar with all the people and staff and aware of any changes in peoples' welfare. The office was the hub of the service and people, relatives, staff and visitors were all confident in stopping by to speak to the matron during the inspection.

On the day of inspection two people had to be admitted to hospital urgently. We saw the effective partnership between the medical centre and the service when staff swiftly reported concerns about a person's worsening condition. Minutes of a meeting between the senior nurses of the service and the medical practice nurses reflected how they were working together towards greater cooperation to increase continuity of out of hours care for people and help reduce hospital admissions for example by trying out ' telehealth', (using technology to get instant diagnosis and responses from doctors). Qualified staff attended training and development opportunities by working with the nurses at the medical centre, and completing online training run by the nurses' registration body, the NMC, which assisted in keeping their registration skills updated.

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 9 HSCA RA Regulations 2014 Person-centred care The provider was not doing everything reasonably practicable to make sure that people received person-centred care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had insufficient policies and procedures to address the administration of medicines. The provider was not ensuring care and treatment was provided in a safe way for people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no effective systems in place to assess and monitor service quality.