Absolute Care Homes (Central) Limited

Boldmere Court Care Home

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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection was carried out over three days on 8, 10 and 11 June 2015 and was unannounced.

We last inspected Boldmere Court Care Centre on 18 November 2014. At that inspection we found the provider was not meeting regulations because they were not informing us about restrictions that had been agreed to be placed on some people's liberty and monitoring the quality of the service provided. During this inspection we found that the provider had kept us informed of the restrictions that had been agreed for people where they were needed. Although improvements had been made on how the quality of the service was monitored further improvements were required.

Boldmere Court Care Centre provides accommodation and support for up to 68 people with nursing and personal care needs some of whom were living with dementia. There were 67 people living at the home when we inspected.

There was a registered manager in post. A registered manager is a person who has registered with the Care

Summary of findings

Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were not always enough staff on duty to ensure that people were adequately supervised and so that their needs were met in the way they wanted. This was a breach of regulations.

Staff understood their responsibility to take action to protect people from the risk of abuse and harm because the provider had systems in place to minimise the risk of abuse. However, we saw that staff did not always follow the risk management plans in place to minimise the risks associated with people's care and this put people at further risk of injury. This was a breach of regulations.

Staff understood how to get consent from people to the care they received and how to involve people in their care. However, we saw that staff had not always recognised when their practices were putting restrictions on people's ability to move around freely. This meant that they were not meeting the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards which meant that people's human rights were not protected. This was a breach of regulations.

People who could tell us told that they felt safe living at the home. Relatives that we spoke with told us that their family member was safe and well cared for at Boldmere Court Care Centre.

People were supported to receive their medicines but medicines were not always available and people did not always receive their medicines as prescribed.

Some staff interaction seen were caring and kind and provided effective, personalised care but was not always based on individual preferences. Staff did not fully understand dementia and the effects that dementia had on people, so staff interactions did not always show compassion and care.

People received food and drink based on their needs and preferences. People were provided with appropriate support to eat their meals when needed. People were not always happy with the standard of the food.

People were supported to receive advice and treatment from a variety of healthcare professionals so that they remained healthy and received treatment if they were unwell.

Staff did not always show care and compassion towards people and were not always responsive to their needs.

Systems were in place to monitor the quality of the service provided but they did not always identify poor practice and ensure the appropriate actions were taken to improve the service.

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 

The service was not always safe.

Staff had received training in how to recognise abuse but did not always recognise care practices that were abusive.

Risks associated with people's needs had been assessed and management plans put in place but these were not always followed putting people at risk of injury.

There were not always sufficient staff on duty to meet people's needs.

There were occasions when people did not receive their medicines as prescribed.

Is the service effective?

Requires improvement 

The service was not always effective

Staff were aware of how to gain consent to the care they provided however, some practices restricted people's liberty and were not reflective of people's preferences.

People did not always received care and support that reflected their needs and wishes and was not personalised.

Most people enjoyed the meals provided but some people felt they could be improved.

People were supported to receive medical attention when they needed it.

Is the service caring?

Requires improvement 

The service was not always caring.

People were treated with compassion and care and their dignity and privacy was maintained during the day but there were times during the night when this was not happening.

People were supported to maintain their independence.

Is the service responsive?

Requires improvement 

The service was not always responsive.

People and relatives were involved in planning and reviewing care needs.

People were supported to maintain contact with people important to them.

People did not always feel that there was enough to do to keep them occupied.

Summary of findings

Most people knew who to raise any concerns with but some people said they did not know who to speak with.

Is the service well-led?

Requires improvement

The service was not consistently well led.

People and staff had opportunities to raise their concerns however, staff did not always feel supported when they had raised concerns.

Audits about the service were carried out on a regular basis but we found the monitoring systems did not always identify shortfalls in the service such as low staffing levels at night and poor care practices so people did not always receive a quality service.

Boldmere Court 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.

This inspection took place on 8, 10 and 11 June 2015 and was unannounced on the first and second days but the manager knew we would be visiting on the third day. On the first day of our inspection we visited at 8.30pm because we had received some concerns about staffing levels at night and was carried out by two inspectors. On the second day the inspection team consisted of two inspectors and expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. For example, for this inspection the expert had experience of services provided to older people. On the third day the inspection was carried out by one inspector.

As part of our inspection we looked at the information we held about the service. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts. A notification is information about important events which the provider is required to send us by law. We considered any concerns or complaints we had received. We looked at reports we had received from the local authority about services. We contacted the local authority who purchased the care on behalf of people so they could give us their views about the service provided to people.

During our inspection we spoke with 16 people that lived at the home, nine relatives, five nurses, ten care staff, and the provider's representative and the person supervising the home's DoLS applications. We observed how people were being cared for using a short observational frame work for inspectors. [SOFI]. SOFI is a way of observing people's care to help us understand the experience of people who live there.

We looked at the care records of six people to check if they had received care according to their planned needs. We looked at the personnel records of two staff to ensure the recruitment process was robust and looked and other records associated with the management of the service.

Inadequate

Is the service safe?

Our findings

All the people we spoke with told us that they were well looked after however some people felt the staff were not available to help them when they needed help. One person told us, "Sometimes I have to wait twenty minutes or more so I have to go to the toilet when it's convenient for the staff." Another person told us, "The carers are good but not enough of them to look after me. I don't see people very often. I know they are very busy and don't have time to stop and chat to me." One relative told us, "There's shortage of staff all the time." Another relative told us, "Boldmere Court is two homes, one in the daytime and one at night. If I could I would stay all night [with their family member]."

The provider's representative told us that staffing levels were based on people's dependency levels however, our observations showed that there were not sufficient staff available to meet people's needs safely. We saw that staffing levels, particularly at night, were not sufficient to meet people's needs. During our visit at 8.30pm on 6 June 2015 we saw that most people were in their bedrooms and there were inadequate numbers of staff on duty to supervise people. As a result one person had a fall. The staff member told us this was unwitnessed and confirmed that they [staff] were on their own as the nurse was on another unit. One person was sitting with their legs hanging over the bedrails, suggesting they wanted to get off the bed. A member of staff told us that the person had been put on their bed as they were at risk of falling if they were left sitting in a chair unsupervised. On another floor there was only one staff member on duty between 8 and 9.30pm because the second staff did not start working until 9.30pm resulting in fewer than the required number of staff being on duty. Both of the care staff on these two units had to seek help from staff from other units when a second staff member was needed.

On another floor we saw that there were two care staff but most people on that unit needed two care staff to assist them with personal care. We saw that one person was lying in a wet bed at 9.45pm. The nurse on duty told us that the bed had become wet recently and the care staff were working their way round to assist the individual. This meant that the person was at risk of developing skin damage due to being wet for a long period of time. Records showed that the individual had last been attended to nearly four hours earlier.

We saw, and staff confirmed, that during the day the staffing levels were better than at night. However, some people told us that they had to wait for assistance during the day too. One person living in the home told us, "One thing I don't like is having to wait to go to the toilet. I ask the staff but they just look at me strangely. Sometimes I have to wait twenty minutes or more so I have to go to the toilet when it's convenient for the staff." Another person told us that they enjoyed having a bath but they also went on to say, "I'd like one more often but they are busy people."

Some staff spoken with stated that sometimes they were short staffed because efforts were not always made in a timely way to organise cover when there were shortages.

During our evening visit we saw that one person who wanted to use the toilet was told that they could use their continence pad rather than supporting them to the toilet. We were told that this was the part of the person's behaviour. We saw that a person who had recently moved into the home was confused and repeatedly asked staff if there was a job for them and where they needed to go. We saw that no efforts were made by staff, apart from the Operations Director, to reassure the individual or respond to their questions. We were told that this was their "behaviour". This indicated that staff did not have the time to respond to people's needs in a way that provided personalised care and did not fully understand and respond to the needs of people living with dementia.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks associated with the care provided had been assessed and plans were in place to ensure that people's needs were met safely. One person told us, "They [staff] give me confidence to use my frame so I am safe." Another person said, "Staff look after me and keep me safe." A relative told us, "When my relative walks with the frame they [staff] watch them to make sure that my relative doesn't fall by walking alongside them". We saw equipment such as wheelchairs, pressure relieving mattresses and cushions were in use to manage people who were at risk of developing skin damage. However, we heard one person

Inadequate

Is the service safe?

say, “My bum is hurting” when they were sitting at the dining room table. We saw that they were not sitting on a pressure relieving cushion although their care plan stated they should be, so the individual was not protected from the risk of skin damage. For another person we saw that the risk of injury had been increased because management plans had not been followed. The person’s care plan stated that bed rails were not to be used as this increased the risk of injury and staff confirmed this. However we saw that the bedrails were in use.

We saw that although call bells were in place in most bedrooms they were not accessible to people so that they were unable to get support if they needed it when they were in bed. Staff told us that only three of the 22 people on that floor were able to use the call bells. The risk assessment for one person who did not have an accessible call bell stated they were able to use the call bell at times but the call bell had not been provided. Risk assessments were not in place to identify who could and could not use their call bells.

People told us they received their medicines as prescribed. One person told us, “One good thing is I don’t have to take any medication except if I’m in pain then the nurses will give me some pain killers.” Another person told us, “Staff give me my medication everyday which is good they stay with me to make sure I have swallowed the medicine.” Most relatives spoken with told us they believed people received their medicines as required but one relative did not feel that sufficient care was taken to ensure their family member had swallowed their tablets. We saw and staff confirmed that medicines were given by trained nursing staff and that they were given to people in a caring way. We saw occasional gaps in the medicines administration records (MAR) because medicines had run out or they had not been given. We saw that a course of antibiotics was stopped with only 13 of the 14 tablets administered.

This is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people spoken with told us they felt safe and the staff were kind to them. One person told us, “I feel safe and well cared for.” Relatives spoken with told us that the staff kept people safe. Our observations of care at night did not reflect what people told us.

Staff told us and records confirmed that training in how to protect people from abuse had been provided. Staff were able to tell us and gave us examples of how abuse could be recognised, for example unexplained bruising and changes in mood. Staff were able to tell us what actions they would take if they saw abuse occurring and which external agencies they could speak with about any concerns. However, we saw that staff did not always recognise that putting people in their bed because of being short staffed could be seen as abusive or telling someone to use their continence pad instead of assisting them to the toilet due to staff shortages could be abusive.

This is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had been notified of concerns of safeguarding that had been brought to the provider’s attention and we saw that appropriate actions were taken as a result. As a result of our findings we made the local authority aware of our concerns.

All staff spoken with said all the required recruitment checks required by law were undertaken before they started working and that they received an induction into their role. Records looked at confirmed this. This showed that the provider ensured that staff were suitably recruited to support people.

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The Deprivation of Liberty Safeguards (DoLS) provide a legal framework around the deprivation of liberty so people's rights are protected. At the time of our last inspection in November 2014 we saw that applications had been made for authorisation for some of the restrictions in place to keep some people safe. However, we were not being kept informed of the authorisations that had been agreed as was required by law. Since that inspection we had been notified about the DoLS that had been agreed by the supervisory body.

At this inspection staff spoken with were able to tell us how they obtained consent from people on a day to day basis so that they were in agreement with the care provided. However we saw that staff did not always recognise where their actions could result in people's liberty being restricted. For example, one person had been put on their bed with the bed rails raised because the individual was at risk of falling if they were sat in a chair. On the day of our inspection staff were not able to provide the level of supervision required to keep them safe. The person's care plan indicated that they preferred to go to bed at 10pm however we saw that the individual was already on their bed at 8.30pm. This indicated that the care provided was not consistent with the individual's wishes and posed a restriction on their liberty to move around. This is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were involved in planning their care and deciding on how they received support. One person told us, "When I came in people talked to me about my care and what I needed." A relative told us, "When our relative came in we all got together to discuss what care package was needed. The staff provides all the care needed for our relative which we are very pleased about."

Some people received the support they needed and wanted. One person told us, "Staff look after me nicely. I love it when I have a bath and staff help me, it's a nice chatty time too."

People received support from staff that were trained and supported to carry out their roles but not everyone was happy with the attitude of some staff. One person told us, "I know staff are well trained to look after me as they know what they are doing." Staff spoken with were knowledgeable about people's needs and how they liked to be supported. For example, staff were able to explain how they communicated with a person who had limited verbal communication. Staff told us they received regular training and supervision and attended staff meetings and felt supported in carrying out their roles. Records looked at showed that there was an ongoing training programme to ensure that the staff skills and knowledge was kept up to date.

Most people spoken with told us they had a choice of meals each day and some people told us the meals were good. One person told us, "The food is nice." Another person told us, "The foods not that bad with several choices at each meal time. " However other people were not always happy with the food they received. On person told us, "One thing I don't like is I get up at 7am and have a nice cup of tea and my porridge but then I have to wait until 1pm for my lunch which is a long time to go without food. Sometimes the foods not good, and at times it can be cold by the time I get it." Another person told us, "I do like a good breakfast but I don't get one very often just every now and again, mainly just toast." A third person said, "The foods pretty awful sometimes but I have fresh fruit on my little table if I get hungry." Relatives spoken with mostly complimentary about the meals provided. One relative said, "The meals are good, well presented and appetising my relative always eats what they provide and regularly check my relatives weight."

We saw that there were choices at lunchtime and the meals were well presented and people appeared to enjoy their meals. People received support with eating where required but some people had to wait for assistance until other people had finished their meals. We saw that specific dietary needs were catered for and referrals were made to dieticians and speech and language therapists where needed to enable people to eat and drink safely.

People were supported to see their GP, attend hospital appointments, or other healthcare professionals such as the dentist or chiropodist so that their health care needs were met. Relatives spoken with felt that people's healthcare needs were met. One relative told us, "If there

Requires improvement

Is the service effective?

has been an appointment with the GP or other professional staff will call me and let me know what the outcome was." During our inspection we saw that a GP had been asked to visit an individual. Records showed that people were seen by the optician, dentist, chiropodist, nurses who specialised in the care of damaged skin and physiotherapists.

Requires improvement

Is the service caring?

Our findings

All the people spoken with told us that the staff were caring. One person told us, "I like living here it's nice. Staff are kind to me and look after me very well." Most relatives told us that they were happy with the care their family members received. One relative told us, "They [staff] are caring and will do anything for [name of person]." Three relatives commented that some staff were better than others. On relative told us that they felt that the attitude of some staff was not good. They said they saw that staff were often on their telephones, watching television, eating their food and not responding to the people they were caring for. Staff spoken with knew people's individual preferences and interactions when people were being supported with their meals were kind and caring. For example, we saw that people were spoken with whilst they were eating and care was taken to ensure that a person's mouth was wiped and drinks offered between mouthfuls of food.

People's privacy and dignity was promoted. One person told us, "I have a bed bath everyday that's done respectfully and nicely by the carers." A visitor to the home told us, "[Person] is always nicely dressed and well presented." A relative told us, "We know dad is befriended, valued and shown friendship. Staff maintained his dignity." We saw that any personal care was provided behind closed doors and people had been supported to dress in individual styles with attention paid to their hair and makeup. We saw that people were covered with a blanket when needed to protect their dignity and people were offered clothes protectors when eating their meals. Staff were able to tell us about the different ways in which they ensured that people's privacy and dignity was maintained. This showed that staff understood that privacy and dignity was important to how people felt about themselves. However, we saw this was not the practice of the staff during our night time visit. We saw that people's privacy and dignity was not always respected.

People were encouraged to be involved in making choices about the care they received so that they were supported to retain as much independence as possible. One person told us, "Staff help me to have a shower which is very nice but they will only wash the places where I can't reach. When they are helping me they tell me what they want to do and how they are going to do it and was that ok with me. That helps me keep my independence." We saw that people were asked where they wanted to sit, what they wanted to eat and if they wanted help to cut up their food. Staff told us that they always asked people how they wanted to be supported and if it was okay to help them.

Requires improvement

Is the service responsive?

Our findings

People who used the service told us they were involved in planning how they wanted their care to be provided so it was personalised to their needs. One person told us, "When I came in staff talked to me about my care." A relative told us, that although their family member could be demanding and challenging, staff had been able to meet their needs in a positive manner. Staff spoken with knew about the people they supported and were able to provide a personalised approach to care based on people's needs some times.

People's changing needs were kept under review. Relatives told us that they were involved in reviewing people's needs. One relative told us, "I'm involved in all the care planning reviews and I feel respected by the team." Another relative told us that they used to attend reviews but hadn't done so recently. Relatives told us that there were meetings that they could attend and raise any issues about the care provided or the service in general.

People were supported to maintain contact with friends and family. People and relatives told us they could visit throughout the day and we saw visitors come to the home throughout the day during our inspection. Relatives told us that they were kept informed about their family member's condition. One relative told us, "They [staff] keep me informed about any falls." Another relative told us, "Staff treat me well too making me welcome and if there are any concerns they will discuss them with me, if I'm not here they will call me at home this means I can relax knowing she is safe and well cared for."

People who used the service told us they were able to join in in some group activities but that these were limited. One person told us, "Trouble is there's not much to do to keep me from getting bored, sometimes I go upstairs when there's some activities going on." Another person said, "It's quiet here with very little to do but there's a new girl started to help me do jigsaws and things like that." A relative told us, "There's not much to do at the home. A singer comes in every now and then." Other relatives told us that they had done some fundraising and a karaoke machine and etch a sketch and so on had been purchased for people to do.

During our inspection we saw that there were some individual activities such as hair dressing and nail painting. We saw that one person was taken into the garden with a football by a member of staff. We saw that some people constantly walked the corridors and some went in and out of other people's bedrooms and they were not supported to be involved in doing things that would occupy them. We saw that a second activities worker had been employed and they told us they had plans to introduce some community based activities such as going to pubs and garden centres and activities that were based on people's individual interests.

Some people told us that would speak to their relatives or the staff if they were unhappy about the care or service they received but some people were not sure who to speak with. One person told us, "If I had some problems or wanted to complain I would talk to me daughter." Another person told us, "If I wanted to complain I would see the staff. On occasions I have somebody else's clothes from the laundry I tell the staff and they take it back." Two people we spoke with told us they were not sure who they would speak with if they were unhappy or wanted to raise a concern.

We saw information about how to raise concerns was available in public areas for visitors and the people who lived there. We saw that meetings with people who used the service, relatives and staff were held to gain their views about the service provided and make suggestions for improvement. We saw that when complaints and concerns were raised these were investigated and responded to in a timely manner. This enabled people to express concerns about the service and gave the provider the opportunity to learn from people's experiences.

Requires improvement

Is the service well-led?

Our findings

At the time of our previous inspection in November 2014 there was not a registered manager in post. Since then the previously registered manager had returned to the home and renewed their registration with us. This meant that the provider was fulfilling their responsibility to have someone in day to day control of the service.

Most of the people, relatives and staff spoken with told us, and we saw that the atmosphere in the home was open, friendly and welcoming. People told us they knew who the registered manager was and saw the registered manager and the provider's representative on a regular basis. People and relatives told us that they could speak with members of the management team, including the administrator, at most times because there was an open door culture to the office. However, two people's relatives told us they did not feel confident in raising issues in case of repercussions on them or their family members. In addition there were opportunities to raise issues in meetings held for people and their relatives. Staff told us they were able to raise concerns at staff meetings.

There was a management structure in place and staff knew about the responsibilities of each person and who they could speak with. Some staff told us that if they did not feel listened to by nurses they could speak to the registered manager or providers representative. Staff were aware of the whistle blowing procedures. Whistle blowing means there were systems in place that enabled employees to raise concerns about poor practice without fear of being penalised for doing so. However, some staff felt that issues were not always adequately addressed when raised with senior staff and confidentiality was not always maintained when actions were taken and felt that they were penalised for raising issues. This indicated that there was a management structure in place for staff to raise concerns with but some staff felt that the management team did not always fulfil their responsibilities appropriately.

We raised our concerns regarding some care practices and staffing levels at night that we observed on 6 June 2015 with the provider's representative. They responded by increasing staffing levels, putting night shift managers in place, taking action to look into the concerns we had raised and to ensure that staff arrived for their shifts on time. Staff confirmed that the manager's had carried out occasional checks at night but the provider's representative told us that they had never seen what we had reported to them. This indicated that the monitoring of the service was not sufficient to identify where improvements were needed in the service provided to people.

There was a quality assurance system in place based on gathering the views of people and auditing of the service at regular intervals. We saw that meetings were held with people and relatives to get their views and a survey was being sent out at the time of our inspection. We saw that many compliments about the service had been received and some complaints had been raised which had been addressed. We saw that safeguarding concerns were logged and referrals made as required but there was no analysis of the causes of the complaints or safeguarding concerns raised to identify possible causes and actions that could be taken to prevent reoccurrence of the issues. We saw that different topics were audited each month and there were action plans that were based on the findings. Care plans were audited and shortfalls were identified and actioned. Although there were regular audits being carried out there was not always sufficient analysis to identify what actions needed to be taken to address issues or minimise reoccurrences. For example, we saw that audits of the administration of medicines had resulted in training for both care staff and nurses. We saw that an audit of some medicines in February had identified some errors but no action plan to address these was found. Our inspection identified that errors were still occurring. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services were not provided care in a safe way and as prescribed. Regulation 12 (1); and 12 (2)(b) and (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: People who use services were not protected from abuse and improper treatment. Regulation 13 (1); 13 (2); 13 (4) (c) (d); 13 (6) (b) and, 13 (7) (b).

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems in place were not operated effectively to ensure compliance with regulations. Regulation 17 (1); and 17 (2) (a) (b) and (e).

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Sufficient numbers of suitably qualified, competent,skilled nd experienced person were not deployed in order to meet people's needs. Regulation 18 (1); and 18 (2)(a).

The enforcement action we took:
Warning Notice