Alo Care Ltd

Bellus Lodge

Inspection report

16 Somerford Avenue
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Ratings

Overall rating for this service	Not sufficient evidence to rate
Is the service safe?	**Not sufficient evidence to rate**
Is the service effective?	**Not sufficient evidence to rate**
Is the service caring?	**Not sufficient evidence to rate**
Is the service responsive?	**Not sufficient evidence to rate**
Is the service well-led?	**Not sufficient evidence to rate**

Overall summary

Bellus Lodge opened on 18 March 2015 and this was our first inspection of the home. We carried out an unannounced inspection that included an unannounced visit to the home on 9 June 2015 and telephone interviews which concluded on 22 June 2015.

Bellus Lodge provides accommodation and care for people with complex support needs. It is registered for up to 6 people. At the time of our inspection there were three people living there.

It is a condition of the registration that Bellus Lodge has a 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. There was a registered manager and we met them during our inspection.

We were unable to rate the service as it is too new for evidence in some areas to be gathered.

People were relaxed and happy when we visited and one person told us they were happy in the home and felt supported to do what they wanted.

Summary of findings

People were supported in a person centred way by staff who were enthusiastic and committed to providing quality care. They understood their roles in relation to encouraging people's independence and safeguarding them in respect of their vulnerabilities.

There were enough staff, however some of the staff were inexperienced in care and had not yet completed all the training the service had identified as necessary. This put people at a risk of receiving inappropriate or unsafe care. The managers had a plan in place to address the training shortfall.

Families felt that they had been involved in assessments but felt less involved now their relative was living in the home. We have made a recommendation about involving families and friends in decisions about people's care.

Difficulties regarding communication agreements between the home and professionals were identified. These were being addressed by both parties.

The provider and staff team were developing the service and a commitment to learning and responding was clear in changes we saw made. Further developments were needed and the managers were implementing systems and structures to ensure these happened.

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?

Not sufficient evidence to rate

People were supported by staff who had not all received training in how to intervene physically if this was necessary to keep the person or others safe. This put people at risk of not being supported appropriately.

People received their medicines as prescribed.

People were supported by staff who understood how to identify and report abuse and neglect.

People were supported by enough staff who had been recruited safely.

Is the service effective?

Not sufficient evidence to rate

People had not had decisions about their care made clearly within the framework of the Mental Capacity Act 2005. This put them at risk of not receiving the least restrictive care. The manager had a plan in place to ensure that this was done.

Deprivation of Liberty Safeguards (DoLS) had been applied for people who needed their liberty to be restricted for them to live safely in the home.

Staff learned how to support people by working alongside more experienced staff and undertaking training. They felt confident to do their jobs but not all training had been done. This put people at risk of receiving inappropriate support.

Is the service caring?

Not sufficient evidence to rate

Staff spoke about people with respect and kindness and we witnessed gentle and respectful interaction.

People were communicated with in ways that suited them and this was used to promote choice.

Is the service responsive?

Not sufficient evidence to rate

People were supported in a person centred way, and had care plans which had been recently updated. There was a process for developing the care plans as staff got to know people better and as professionals input into their care.

There was a complaints procedure available. It had not been used at the time of our inspection.

Summary of findings

Is the service well-led?

Not sufficient evidence to rate

Staff felt supported by the managers and understood what the home was aiming to provide.

Systems and structures were being developed and embedded to reflect the needs of the developing service.

Bellus 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 unannounced inspection was undertaken by one inspector who visited the home on 9 June 2015. After the visit we spoke with three healthcare professionals, a social care professional, two relatives and a further two members of the care staff team.

Before we visited the home we reviewed information we held about the service. We had not asked the provider to submit a 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. We were able to gather this information in other ways including talking with the registered manager and manager.

During our inspection visit, we spoke with a person who used the service, observed staff interactions with two people who used the service and spoke with four care staff, the manager and the registered manager.

We looked at records relating to the care of the three people living in the home including care plans, risk assessments and medicines records. We also looked at records related to how the home was run including rotas, meeting minutes and audit records.

Not sufficient evidence to rate

Is the service safe?

Our findings

People living in the home had difficulties managing their emotions and sometimes needed staff to intervene to help the person calm and to protect both the person and other people. The emphasis of the home was on providing personalised support that enabled the person to stay calm and engaged in activities that were meaningful to them. Care plans described communication tools, activities and distraction methods that all contributed to this approach. Staff told us they felt confident that they had the guidance and support necessary to do this safely.

The three people living in the home sometimes needed physical intervention to keep them safe. This was mostly a structured low arousal method but we read one incident report that included the necessity for an unplanned physical intervention. The person was made safe and both the person and the staff involved were supported afterwards. Not all staff were trained in how to do intervene physically in a safe way. There was a risk that people and staff could be hurt if physical interventions were not carried out safely. We spoke with the manager and registered manager about this. They showed us that all staff were booked to complete the training and that in the interim there was always one person on shift trained in these techniques. They also explained that the on call was always less than 15 minutes away and they were called at an early stage when someone is anxious or agitated. Most staff had completed a course that provided them with an awareness of challenging behaviour.

The risks people faced were documented in their care plans; staff spoke confidently about how they kept people safe whilst supporting them to have opportunities to live a full life. The staff were developing their knowledge and a recent review of care plans and risk assessments based on developing knowledge was evident. Relatives told us they believed their relative was safe in the home.

Medicines were stored and administered safely. There were some medicines in the cabinets that needed to be returned to the chemist. We asked about these and the manager explained they would be picked up by the chemist that day. People received their medicines when they needed them and there were systems in place to check that 'as and when' medicines were used only when necessary. Care plans described when medicines were needed however; staff were also expected to discuss giving the medicine that was prescribed to help people calm down with the on call before administering it. This check was in place because people with complex needs who sometimes hurt themselves or others when they are distressed are at risk of being given medicine to keep them calm when other interventions such as distraction may achieve the same outcome. Staff told us that this check did not cause them a problem. There was a recorded incident when the on call was not available to support staff to make this decision and a visiting healthcare professional had told the staff to administer the medicine. We spoke with staff about this and they said this was an isolated incident. The on call involvement in administering these medicines was a positive system to ensure staff used the least restrictive methods but there was risk that if the on call system failed, staff may not be confident to give medicines without permission.

Staff understood their role in protecting people from abuse. They knew what they should be aware of and who they could raise any concerns they had with.

There were enough staff to meet people's assessed needs. During our inspection we heard from staff and saw that they had time to work alongside people in ways that met their needs. Staff supported each other to take breaks when necessary and to vary the tasks they were undertaking. Staff told us that they had always been able to ensure there were enough staff but that initially this had meant some staff working long hours. They told us that this was no longer the case and the rota largely reflected this. The support people needed could be very focussed and intense for staff. We saw that they were deployed across a range of tasks with regular short breaks during our inspection. This supported them to give people positive attention throughout their shift.

We reviewed the files of four members of staff and saw that appropriate recruitment checks had been made. These checks reduced the risk that any person unsuitable for this employment was taken on as a member of staff.

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Not sufficient evidence to rate

Is the service effective?

Our findings

People living in the home had varying mental capacity to make decisions about their care. The Mental Capacity Act 2005 provides a legal framework for making decisions on behalf of people when they do not have the capacity to make the decision for themselves. The MCA had not been implemented and this meant that capacity assessments had not been undertaken and decisions about people's care had not been agreed following best interest principles. This meant that all appropriate people had not been consulted and that there was a risk that care would not be provided in the least restrictive way. Staff spoke about people doing what they wanted but did not have a clear understanding of the importance of capacity to make decisions. The member of staff appointed to undertake staff training identified this and told us that MCA training was a priority. We discussed this with the manager and saw that it was raised in the senior staff meeting on 10 June 2015 and clear action was planned.

One person living in the home had a Deprivation of Liberty Safeguard (DoLS) in place and these safeguards had been applied for for two further people. DoLS aim to protect the rights of people living in care homes and hospitals from being inappropriately deprived of their liberty. The safeguards are used to ensure that checks are made that there are no other ways of supporting the person safely.

Staff learned how to carry out their role by shadowing and working alongside more experienced staff and undertaking training. The staff team was new and some staff had not completed all the training the provider had identified as essential. For example, less than half the staff had completed infection control. We spoke with the manager who explained that staff were in the process of completing this training and that staff who were taking on supervisory roles would support and ensure this. We saw that dates were booked in for practical training sessions.

Most staff told us they felt supported to carry out their roles effectively. One member of staff told us about how any queries they had had were dealt with saying, "I've always got an answer and an explanation." Most staff told us that the more senior staff team, which included the registered manager, were available to ask advice. However, one member of staff did not always feel supported by all the staff and managers. There was a risk that inexperienced staff may make errors that could be avoided by undertaking appropriate training, and the managers had identified this as a priority. A role that included staff training and care planning had been established to ensure that training needs matched the needs of people living in the home. This built on training sessions already established to ensure that all staff understood how they should be following guidance from a psychologist.

People's health care needs were being addressed as part of their support plans and records were kept of medical appointments. As staff became more familiar with people these plans were being developed. For example a new dentist was being sought for one person who had not had a dentist for some time.

Communication between healthcare professionals and the team in the home was identified as requiring improvement by both parties. For example, there had not been a shared understanding about the time frames for sharing information. The registered manager described how this was being addressed through agreements with commissioners and healthcare professionals. There was a risk that people would not have their needs met effectively if communication lacked clarity.

Staff knew what foods people liked to eat and where possible they were supported to prepare food. Menus were planned based on people's preferences and with the intention of broadening people's food choices. We observed one person who was at risk of weight loss being encouraged to eat and having access to snacks of their choice. Records showed that this person had recently lost some weight. Whilst this was within the bounds of their historical weight fluctuation the member of staff with specific responsibility for training and care planning identified that they would be supporting staff to understand new ways to encourage healthy eating and ensuring that the person's care plan reflected this.

Not sufficient evidence to rate

Is the service caring?

Our findings

Staff were enthusiastic about their roles and spoke about the support they provided with pride and passion. Staff told us "I love my job." Another described how they were motivated by seeing people living in the home happy and engaged. Family members reinforced this; one relative commented that their relative appeared to have 'a rapport' with all the staff. Another relative told us, "On the whole they have shown nothing but kindness."

We observed a calm environment where people were treated with respect and care by attentive staff. For example, staff offered choice and provide space for the person to consider this without pressure. People's strengths and skills were referred to as part of general conversation. One person told us the staff were 'very friendly". Another person communicated that they were at ease with the staff by smiling and interacting with them as they chose food.

People's privacy was respected by staff in the home. There was a balance maintained between providing personal space and time and ensuring safety. Staff discussed this balance with us sensitively.

Staff were learning people's communication styles and were using these in their interactions with them. For example they considered how to phrase information so that it could be best understood and they were using a pictorial exchange communication system (PECS). PECS is used to support people to initiate communication and by using it the staff enabled the person to make choices and have influence. People chose how to spend their time, including going out, whilst we were visiting the home and staff were available to support this.

Staff had an understanding of people's histories and what mattered to them and we heard consistent information across the staff we spoke with.

Not sufficient evidence to rate

Is the service responsive?

Our findings

People had comprehensive care plans and these were being developed and added to as staff learned more about the person and their experience in the home. People's involvement in care planning was varied and reflected their abilities. One person told us about their long term goals and these were reflected in the support plans that had been devised. Where people did not communicate with words their care had been devised based on detailed person centred assessments.

Family members told us they had felt involved during the initial comprehensive assessment of their relative's needs but did not feel so involved now. Two relatives commented that they weren't clear on progress around issues that were of concern to them because they had not been updated by the staff team. Whilst personal choice and confidentiality must be considered it is important that the views, knowledge and experience of family and friends are drawn on to ensure personalised care and support.

Ongoing developments in care plans were evident and there were systems being embedded that were designed to ensure that learning from incidents, accidents and other important information was implemented within care plans in a timely manner. Two professionals expressed concerns about how quickly their input was formalised in care plans. The member of staff who had been appointed with a specific responsibility for care plans and staff training identified this would be included in their role. Staff were able to discuss how professional input influenced the care they provided which meant that professional advice was reflected in the care people received.

Care plans included information about how people liked to spend their free time and during the inspection people went out to undertake activities they enjoyed. One person's care plan had been updated with detailed risk assessed guidance around a wide range of activities which staff could offer the person to help them make meaningful choices about how they spent their time.

The home had a formal complaints system but this had not been used at the time of our inspection. The informal concerns of professionals identified during our inspection were being addressed through scheduled meetings. Relatives had mixed views on how responsive the home was. One relative felt they were able to highlight concerns and gave an example of a time they had spoken directly to a member of staff and felt their view had been heard. Another relative didn't feel they had been heard but knew their concern was being addressed.

We recommend that the service seek advice and guidance from a reputable source, about supporting families and friends to express their views and involving them in best interest decisions about the care, treatment and support of people.

Not sufficient evidence to rate

Is the service well-led?

Our findings

Staff told us they felt the service was very open with the registered manager and manager available to discuss issues with. For example, one member of staff said, “He is a good manager”, another said, “They are all approachable.” Another member of staff said, “it is very open here.” They told us they felt that the management were concerned with staff development and providing a quality service. One member of staff said, “Whatever they do they try to do well.”

The on call system was designed to help senior staff understand what was happening in the home and to support staff. Senior staff were available by phone if staff needed advice and support. The on call was based no more than 15 minutes from the home and contacted the staff working in the home at regular times through the day and evening. This ensured they had a good idea of what had been happening and how people and staff were. The registered manager had been on call the night before our inspection and he was able to accurately describe what people in the home had been doing based on his telephone conversations with staff. Staff told us that although they didn’t always see the registered manager on a daily basis they had daily phone contact.

As the service developed the senior staff had reflected on the management structure and were planning changes to meet the needs they had identified. The manager who was in the home day to day was about to apply to become the registered manager which would enable the current registered manager to take an overview of the whole service. Both the registered manager and manager were explicit about their aims for the quality of the service and the staff reflected this emphasis on quality personalised care. A member of staff reflected this commitment to quality saying the home was all about “making this a place like no other” with an emphasis on “moving on”. It is important in a new service that the values and aims of the service are embodied by senior staff on a day to day basis. Relatives, and professionals, expressed concerns that the registered manager was not visible in the home; however, they were not aware of planned changes to the management structure.

Quality assurance systems were being developed and we saw that the first audits had led to some actions being identified and undertaken. The senior staff team started a weekly meeting during the week of our inspection. During this meeting they discussed the outcome of their own audits, issues raised during our visit to the home and requirements made following a fire safety inspection. Actions were allocated amongst the team to ensure all work was undertaken. This included a review of accidents, incidents and reports. The first meeting identified how these would be reviewed and also identified a practical response to an accident that had happened which would reduce the likelihood of a repeat incident. We spoke to three staff who attended this meeting and the registered manager. They were all committed to this providing a framework for them learn as an organisation and to focus on developing the service.