St. Cloud Care Limited

The Boynes Care Centre

Inspection report

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Ratings

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

Overall summary

This inspection took place on 27 & 28 April 2015 and was unannounced.

The service is a care home with nursing which is registered to care for 40 people. Accommodation and personal care are provided to older people requiring personal care and nursing. The service also housed a Respite Care Unit that specialised in offering families a short break by caring for people living with Multiple Sclerosis (MS). There were 23 people living at the home when we visited and there was an interim manager in post. A permanent manager had recently been recruited and was due to take up the post shortly. 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 and associated Regulations about how the service is run.

People were very positive about the care they received and about the staff who looked after them.

People told us that they felt that felt safe and staff were able to tell us about how they kept people safe. However, people's care and social needs were not always met as

Summary of findings

people felt staff were under pressure and that they were short staffed. People received their medicines as prescribed and at the correct time and medications were safely administered and stored.

People and families told us they were respected. However we did not feel that people's care was delivered in a dignified way. People did not always receive care that was based on their preferences and choices and centred around them as a person.

The provider did not act in accordance with the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). The provisions of the MCA are used to protect people who might not be able to make informed decisions on their own about the care or treatment they receive. Staff and the Manager had some understanding of the law but some staff were less confident in applying the law.

We found that people's health care needs were not always assessed, and care planned and delivered to meet those needs. People did not always access other healthcare professionals that provided treatment, advice and guidance to support their health needs and families told us that they felt that further help was sought when needed.

People were supported to eat and drink enough to keep them healthy. People had access to choices at mealtimes. Where people had special dietary requirements we saw that these were provided for.

Staff were provided with training that was continually updated that helped them understand how to care for people in most areas. The registered manager told us that all staff received training and regular checks were made to ensure that everyone received the right training.

People and staff told us that they would raise concerns with senior staff or the interim manager although they did not always raise issues of concern. The interim manager made regular checks to monitor the quality of the care that people received. However, there had been a number of staff and managerial changes within a short space of time which had impacted on how the quality of care had been monitored. The interim manager was working on improving the service and acknowledged that some areas required more immediate improvement, areas such as person centred care and improving the dignity of people at 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?
The service was not always safe.

People were safe from harm because staff understood how to keep them safe. However, staff were not always available to meet people's needs.

Requires improvement

Is the service effective?
The service was not always effective

Staff did not always have the appropriate skills and knowledge to meet people's needs and to ensure people received effective care.

People were able to make choices and were offered a healthy balanced meal.

Requires improvement

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

People liked the care staff and thought they were very caring. However, people were not supported adequately to make decisions about their care or treated with the dignity expected.

Requires improvement

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

People were not able to express preferences about their care as such they did not receive personalised care. This also impacted on people's dignity, and people did not receive dignified care.

Requires improvement

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

People also did not benefit from the arrangements in place to monitor the quality of care. The provider had tried to seek a permanent registered manager and the delays in securing this had meant the quality of personalised care was not always monitored.

Requires improvement

The Boynes Care Centre

Detailed findings

Background to this inspection

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

The inspection took place on 27 & 28 April 2015 and the inspection team consisted of one inspector.

Before our inspection we looked at the notifications that the provider had sent us. Notifications are reports that the provider is required to send to us by law.

As part of the inspection, we spoke with five people who lived at the home and one relative. We also spoke with four care staff, the manager, the operations manager, a GP and two other nurses visiting the service.

We observed care and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at four records about people's care, staff duty rosters, complaint files, training dates and audits about how the home was monitored.

Requires improvement

Is the service safe?

Our findings

People told us they felt the service was short staffed and that they did not always get the support they needed. We asked the Operations Manager to tell us how staffing requirements were reviewed. We were advised a monthly review took place of staffing which included the Respite Care Unit. The total number of staff was then reviewed and adjusted accordingly using a dependency tool. However, when we spoke to staff, they told us they were concerned that there had been a huge turnover of staff recently and in particular nursing staff. Agency staff had been recruited and where possible the same staff were used but visiting health professionals told us they did not feel enough of a staff presence. One told us, "I don't often see many staff…have to go and physically find staff." We asked people in both the Respite Care Unit and the rest of the service whether they thought there were enough staff available. People in the Respite Care Unit confidently stated that they thought there were lots of staff available. However in the rest of the home, people told us they thought there was a staff shortage and that they didn't want to bother staff. One person told us, "They're not always prompt…..they're short of staff." When we asked staff whether they thought there were enough staff, one staff member told us, "I probably don't get as much time as I'd like with people." The differences in people's experience suggested that staff were only deployed effectively in the Respite Care Unit as both the Operations Manager and Interim Manager stated there was a full team of staff across the service in order that people could receive the support they needed. The Respite Care Unit also had a stable team of care staff that was led by a Unit Manager that had been there for a number of years and had developed caring relationships with people using the respite service and their families.

People we spoke with told us they felt safe and the staff treated them well. One person said, "I'm perfectly safe here. I have no doubts about the safety here." Relatives also told us they thought their family member was safe. They told us that they felt their family members received the right care and that that care staff treated them well. We also spoke to a number of professionals who visited that day who told us they thought people were safe from harm.

Staff we spoke with told us how they would respond to allegations or incidents of abuse and who to report these to. One staff member said, "I'd speak to [Interim manager]". The interim manager was filling in for approximately 6 weeks until the new registered manager formally took up the position. Staff told us that they were confident to report any suspicions they might have about possible abuse of people who lived at the home. They were also aware of external bodies that concerns could be reported to. Staff were also very clear that they had a responsibility to raise any concerns they had. Staff who had a line management responsibility also told us about they would manage issues of concern both with the staff and with management if necessary.

During our observations, we noted that staff had a good understanding of people's individual risks. For example, we observed a person who required support when mobilising. We saw how staff walked behind the person to offer reassurance. Staff told us about how some people required specific support at mealtimes because of particular risks. They sat with people and were aware of the risks to look out for to ensure that people were supported safely. We also saw people being supported using a hoist when needed. Staff explained the person what was happening and the person was settled as the transfer to the hoist took place.

Staff were able to describe to us their induction process and how this had prepared them for the role. They undertook a mixture of shadowing other people as well as undertook training. Staff told us they felt the induction had prepared them well.

People told us that staff looked after their medicines for them and that they were happy for them to do so. One person told us they were relieved to have help with their medications when staying on respite. People's medicines were up to date and had been recorded on the Medication Administration Record (MAR) sheet. We saw nurses provide medication to people reminding them what it was and providing prompting where needed to make sure they took it safely. We spoke with nurses on duty that administered the medicines and they were knowledgeable about the safe handling of medicines. For example, they gave us specific examples about people who lived there, the medicines they needed and the specific support each person required. Medication was appropriately stored and disposed of as there were a number of appropriate bins for sharps as well as medications that needed destroying.

Requires improvement

Is the service effective?

Our findings

People did not consistently access appropriate medical support when required. We saw some examples when appropriate advice had been sought and some examples when they had not. We spoke to medical professionals visiting the service and asked them whether they thought staff made appropriate referrals to them. They told us they thought referrals to other services were not always made appropriately and quite often, staff did not know people well enough as they were temporary staff. We reviewed four care records for people that lived at the service which were not up to date with reviews. One person had significant weight loss over three months but the matter had not yet been referred to anybody else to investigate. When this was queried with the interim manager, they agreed that this had not been picked up. The interim manager told us that a manager or a nurse would have normally picked this up when reviewing care records. As there had been a number of interim managers and temporary nurses working at the service recently, the current interim manager agreed that it was possible that issues might have slipped through without being picked up. Although this matter was immediately referred to doctor, concern was raised about whether it was possible that other people might require further medical attention. The interim manager agreed that all care plans would need to be reviewed to ensure there were no other aspects of people's care that required further attention.

Staff told us that there had been a significant improvement since the interim manager had been in post. Staff told us that they could speak to him and that supervision meetings had begun again. Staff told us they could access as much training as they felt they needed, one staff member told us, "I'm offered all the training I need." People benefitted from staff that understood their roles. Staff in the Respite Care Unit had been offered a number of courses to support them to offer specialised care to people living with MS. For example, one staff member was now being supported to develop a more managerial role. We noted that the interim manager had been liaising with the local authority and the internal training lead to ensure staff training was updated.

We looked at how the Mental Capacity Act (2005) had been implemented. This is a law that provides a system of assessment and decision making to protect people who do not have capacity to give their consent. We also looked at Deprivation of Liberty Safeguards (DoLS) which aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

It was not clear whether care staff understood the impact on care of the legislation. Two staff we spoke to were clear told us they were aware of a person's right to choose or refuse care. They were able to tell us about what safeguards needed to be in place when people could not make decisions for themselves. One staff member said, "You can't make somebody have a shower." However, the other two staff were unsure and a little unclear how equipment, such as handrails, might restrict a person's movements by preventing a person from being able to leave their bed. The interim manager told us that some staff training had already been arranged as they recognised a number of staff had either left or joined and were aware all staff needed to understand how people's care could be restricted. We were advised training on the subject had been prioritised.

People we spoke with told us they enjoyed the food and were always offered a choice at mealtimes. One person described the food as, "Tasty." People told us they enjoyed their meals. If

people required help staff were quick to respond. Staff told us about the food people liked, disliked and any specialised diets. We saw one person had a specific allergy and was offered food that avoided their allergy. This matched the information in the care files we looked at and what people told us. One person was at risk of choking and was observed by staff their meal. Staff recorded and monitored information to ensure that people's nutritional needs were met.

Requires improvement

Is the service caring?

Our findings

People told us about some of the ways in which they were supported to maintain dignity and respect and there were some positive examples seen; however this was not consistently applied to all areas of people's care. People told us that important aspects of their care that they valued were not fulfilled and this did not support them maintaining their dignity. People told us they would like to be able to decide when and how often they took a bath and have more involvement in making these decisions affecting their care. At present people did not decide when and how often they received a bath. One person told us, "I haven't had a bath for three weeks. I don't like showers". We spoke to staff to understand the context of the issue raised. Staff showed us a bathing rota, kept in the bathroom that listed the days people had been allocated a bath. We identified our concerns to the manager, who agreed the situation was not acceptable and advised and that people's preferences needed to reviewed and needs met.

This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People told us they liked the care staff and that they felt cared for. People talked highly of the staff that cared for them. One person said, "They do a marvellous job." Another person told us, "I'm very well looked after." People were very keen to tell us that they felt cared for. One person told us, "The staff are very nice." Another person described the staff as "Very good." People told us they liked the staff and received the care they needed. One person said, they were "Very happy"

Some people asked to show us their bedrooms. We saw that the bedrooms had been personalised to reflect their choices. People had personal items in their rooms, such as photographs on the wall, to make their individual space homely as possible. People told us they were happy with the care that they received from staff. We saw that people were relaxed and at ease with care staff and quite often staff were pro-active in initiating conversations with people and maintaining conversations with them. People knew the names of care staff and it was

Care staff regularly chatted with people and checked to make sure they did not need anything. One person who chose to stay in their room, told us that staff would regularly pop in to check that they were alright. One person also told us that they could ring the bell anytime and staff would respond.

People were supported to maintain relationships with people who were important to them. We saw relatives drop in throughout the day to visit their family members. Relatives told us that they were able to visit whenever they chose but were also kept informed of their relative's conditions via telephone if there were any changes. One relative told us, "I can come and go as I please." Relatives told us they also kept in touch by phone and that they were advised of any changes by care staff.

Requires improvement

Is the service responsive?

Our findings

People told us they did not always get asked about what they would like do and to make decisions about their care. This impacted people's care because people did not receive care that was either specific to their care needs or allowed them to feel that they could ask for things. We asked people to tell us whether they were involved in meeting with care staff to decide how their care was planned. One person told us, "They haven't involved me." Another person told us, "No one's asked how I'd like to be cared for." A further person stated, "They do their job really well but they don't involve me." People told us about aspects of their care they would have liked to change. One person described how they would have liked to specify a same sex care staff member, to offer personal care. We saw lots of care staff of both genders available. We raised this with the interim manager who agreed to review this that it was possible but hadn't been offered on this occasion.

When we spoke to people in the service people told us they did not always get to participate in activities that were meaningful to them. We asked people to tell us what they would have liked to do. People described to us a range of things that were important to them such as going outside into the garden or having people come in and give talks. People were able to articulate very clearly past times they would like to undertake. When we asked whether they had ever been asked what they would like to do, people did not feel they had been given an opportunity to do so.

People's experience of the Respite Care Unit was different. People in the Respite Care Unit who predominantly attended the service for a short stay told us they received lots of choice. They described to us "Pub lunches", "Shopping trips" and trips to motor museums. People in the unit were very happy with the choices on offer to them. The manager of the Respite Care Unit described people as "guests" and described how likes and dislikes were established early on in the visit so that were possible people undertook the activities they would like.

People told us that they were aware of how to raise complaints although they had not wanted to raise a complaint. Throughout the inspection people raised issues affecting their care but hadn't complained because they thought care staff were already under pressure and didn't want to bother them. People felt their requests at times might be perceived as trivial. For example, one person told us, "They haven't got the staff to do this and to so that" suggesting that care staff were only available to deliver basic care duties. People told us that the interim manager routinely came around and chatted with them to check that everything was alright and they would speak to the manager if needed. The interim manager also told us that they preferred to resolve issues by chatting to people to understand if there was anything else they needed. We reviewed complaints and comments that had been raised about the service. We saw that complaints had been reviewed, acknowledged and responded to by either the manager or the provider.

Requires improvement

Is the service well-led?

Our findings

Within the service there were areas that required a managerial oversight so that the quality of care could be monitored and improved. At the time of inspection, an interim manager was in place and was the third manager in a space of 9 months. A permanent registered manager had been recruited and was due to start at the service shortly. The interim manager had within a short space of time recognised that improvements needed to be made and had begun to address these.

For example, updating all the medication training for care staff. Despite this enormous effort, there were areas of people's care that meant they did not always receive a positive experience of the service. For example, the interim manager was not able to describe to us a system that allowed people to demonstrate how they would like to be cared that was personalised to them. We raised issues that people had highlighted to us during the inspection that affected how they were cared for. The Interim manager acknowledged that at times people did not receive personalised care and that their care records did not reflect personal preferences and choices. The interim manager told us that they had started to review people's care needs to bring them up to date but this task was not yet complete and acknowledged further work needed to be done.

Although the operations manager told us that they reviewed staff files, supervisions, daily records and care plans on a regular basis. This was inconsistent with some of the findings of the inspection. We asked the operations manager to tell us about audits and checks made to ensure that the registered manager was doing their job effectively and that any changes in quality could be measured. The operations manager told us they audited the training, the number of appraisals completed, staff vacancies as well as complaints. However, many of the issues identified in the inspection had either not been identified or had been missed due to the recent changes within the management. For example, the provider's audit had not picked up that people in the respite service had a different experience than others living there. Also, people we spoke to repeatedly raised areas of their care that they would like to change or identified things they would like to do, yet these concerns were not always captured nor delivered. People's experience of the service was not always positive and did not correlate with what the Provider was doing to understand how to measure quality at the service.

The manager did tell us that questionnaires were regularly sent out to people and their families in order to understand how they could improve the service. Staff surveys were also sent out and these were being analysed at the time of inspection and were not available to review.

The changes in management had created some uncertainty for the care team as well as for people. People had recognised that that there had been a number of different managers in recent months but told us that they liked the current interim manager and did not want him to leave. People and staff were overwhelmingly positive about the current interim manager. People were pleased to see the manager and people engaged the interim manager in conversation and were relaxed and comfortable around them. We saw the interim manager regularly go out of the office and check that people were happy. People told us they thought the interim manager was "Lovely."

The interim manager was supported by team leaders who line managed the care staff. Nursing staff were managed directly by the interim manager. Staff we spoke to told us that there were now regular supervisions and team meetings. There had been a number of recent changes within the teams and a number of staff had left which had caused some uncertainty within the team. However, staff told us that they could approach the interim manager and discuss any concerns they might have had. The operations manager described to us a number of changes brought within the team to offer reassurance to staff. The interim manager told us that the changes were also necessary in order to improve the service. All changes had been communicated to staff and staff we spoke to were aware and understood the changes. .

We noted that many of the areas of concern had arisen because of the lack of leadership. People's care needs were not updated or had not been fully captured. People thought there were not always staff available and differences in people's experience of staying at the service were beginning to emerge. There was inconsistency across the service. People in the respite unit described a positive experience, which was person centred. People using the rest of the service were not always as engaged in activities or being cared for with the dignity they expected. The

Requires improvement

Is the service well-led?

provider had attempted to provide leadership through a number of temporary managers whilst a longer term solution was identified. However, at present there were not enough examples presented to us to demonstrate that the service was being monitored effectively enough to provide good quality care.

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 9 HSCA (RA) Regulations 2014 Person-centred care People who use services did not have care and treatment that was appropriate, met their needs or reflected their preferences.