Cooper Residential Homes Limited

Bethel/Bethesda Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service effective?	**Requires Improvement**

Summary of findings

Overall summary

We inspected the service on 16 January 2017 and the visit was unannounced. This meant the provider and staff did not know that we would be visiting.

We carried out an unannounced comprehensive inspection of this service on 26 August 2016 and 1 September 2016. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements. We issued a warning notice in relation to the breach of Regulation 11; need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We undertook this focused inspection to check that they had followed their plan and to confirm that they now met the legal requirement. This report only covers our findings in relation to this requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bethel/Bethesda Residential Home on our website at www.cqc.org.uk.

At the last inspection we carried out on 26 August 2016 and 1 September 2016 we found that where people lacked the capacity to consent to their care and treatment, the provider had failed to act in accordance with the provisions of the Mental Capacity Act 2005 (MCA). We also found that staff did not understand their requirements under the Act. At this inspection we found the provider had made some of the required improvements.

Bethel/Bethesda Residential Home provides care and support for up to 34 older people. At the time of our inspection 18 people were using the service and some were living with dementia or similar conditions.

There was a registered manager in place. It is a requirement that the service 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.

People were not always supported in line with the Mental Capacity Act 2005 (MCA). People were not always asked for their consent before staff carried out care and support. Where there were concerns about people's ability to make decisions, the provider had not completed assessments in line with the MCA. Decisions made in people's best interest were not recorded to show how these had been agreed. Staff understood their responsibilities under the Act. The provider had made applications to the appropriate body where they had sought to deprive a person of their liberties.

Staff received training and guidance relevant to their role. The guidance they received was not always effective. For example, staff did not always communicate with people when offering their support.

People had mixed views on the food available to them. The registered manager was taking action to make sure improvements were made. Where there were concerns about people's eating and drinking, people's

care records were not always full completed to provide guidance to staff. The registered manager told us they would review people's records where the information was not complete to make improvements. Staff knew what actions to take should they have concerns about people's eating and drinking.

People had access to health care services such as their doctor and district nurse visits.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service effective?

Requires Improvement

The service was not consistently effective.

We could not improve the rating for effective from requiring improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

We found that some action had been taken since our last inspection to improve how the service was effective.

People were not always supported in line with the Mental Capacity Act 2005. Where there were concerns about a person's mental capacity, the provider had not always followed the principles of the Act. Staff knew their responsibilities under the Act and were receiving training in this area.

Staff received guidance from the registered manager about their work. Staff did not always follow this guidance as some people were not asked for their consent to the care offered.

People had mixed views on the food offered to them. The registered manager was taking action to make sure people's views were heard and acted upon.

Where there were concerns about people's eating and drinking, their care records were not always fully completed. Staff knew what action to take if they had concerns about people's eating and drinking.

People were supported to maintain their health.

Bethel/Bethesda Residential 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.

We undertook an unannounced focused inspection of Bethel/Bethesda Residential Home on 16 January 2017. This inspection was done to check that improvements to meet a legal requirement planned by the provider after our inspection on 26 August 2016 and 1 September 2016 had been made. We inspected the service against one of the five questions we ask about services: is the service effective. This is because the service was not meeting a legal requirement.

The inspection team included an inspector and an expert by experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit we reviewed the information that we held about the service to inform and plan our inspection. This included information that we had received and statutory notifications. A statutory notification contains information relating to significant events that the provider must send to us. We contacted the local authority who has funding responsibility for some people living at the home to ask them for their feedback about the service.

We spoke with nine people who used the service and with the relatives of three other people. We also spoke with the registered manager, the proprietor, two cooks, a senior carer and three care assistants. We observed staff offering their support to people throughout our visit so that we could understand people's experiences of care.

We looked at the care records of five people who used the service. We also looked at records in relation to

the training staff had received since our last inspection. We viewed three staff files to look at how the provider supported their employees.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection carried out on 26 August 2016 and 1 September 2016 we found that where people lacked the capacity to consent to their care and treatment, the provider had failed to act in accordance with the principles of the Mental Capacity Act 2005 (MCA). We also found that staff were not fully aware of their responsibilities in relation to the Act. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; need for consent. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had made some of the required improvements.

The MCA provides a legal framework for making particular decisions on behalf of people who may 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. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the provider was working within the principles of the MCA.

People told us that staff usually asked them for their consent before assisting with care. Comments included, "They always ask me before doing things", "They often ask me first to see if I'm ready to do something" and, "They help me to dress and ask me if I'm ready for them."

We saw that staff were inconsistent when asking people for their consent before delivering care and support. One person was assisted to move from a wheelchair to an arm chair. We saw that staff did not ask for the person's agreement or that they wanted to be moved. Another person was assisted to a dining room table. We heard staff say, "Where's she sitting." Another staff member replied, "I'm going to put her there." The person was not asked for their choice of position within the dining area. At other times we saw that staff asked for people's consent when offering their assistance. We saw a person supported in their room and staff carefully asked for permission before assisting them. The registered manager told us that they would remind staff about the need to gain people's consent and talk with them about what they were doing.

Where people could not consent to their care and support, the provider had completed mental capacity assessments to determine people's capacity. However, these were not always specific to individual decisions that were required to be made and not completed in line with the MCA. We saw that four people were assessed as generally not having the mental capacity to make decisions. People's records did not show how people had been supported to try to make the decision or what decision had been made in people's best interest. We did not see who was involved in making decisions on people's behalf where people were assessed as not having mental capacity. The provider told us they were receiving support from the local authority's 'quality improvement team'. They said they would seek further guidance about mental capacity assessments and the recording within people's care records of any decisions made in their best interest.

People can only be deprived of their liberty to 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 hospital are called the Deprivation of Liberty Safeguards (DoLS). We saw that the provider had made the appropriate

applications to the 'supervisory body' (the local authority) where they were seeking to deprive someone of their liberty. Where there were conditions to an authorisation we saw that these were met by the provider.

Staff understood the requirements of the MCA. One staff member told us, "If someone deteriorates we check for a water sample as that can affect someone's ability to make a decision." Another said, "You would do an assessment on them. Some people's children have the authority to make their decisions. It's called a power of attorney. If that's in place they can make decisions on the person's behalf." Staff members knew that a DoLS authorisation might need to be in place if there were restrictions on people, such as them requiring constant supervision to remain safe. A staff member told us, "We would do an assessment if there were concerns about someone's understanding. The manager does these at the moment. If needed you would then send off for a DoLS authorisation. Usually they come out and assess to make sure what we are doing is safe." The registered manager told us that further training was planned for staff in the next two weeks to enhance their knowledge.

People and their relatives told us that staff members had the necessary skills and knowledge. One person said, "They handle me well with the hoist [moving equipment]." Another person told us, "They seem a well-trained team." A relative said, "I'd say they've been well trained. I used to work in care myself." Staff members felt that the training provided enabled them to offer good support to people. One staff member told us, "The training is useful and enough. We've done DoLS and pressure care recently. It gives a different insight into things and is helpful to learn about." We saw that staff had received recent training in the MCA. This meant that the provider had responded to our concerns found during our last inspection about staff's understanding of this legislation.

Staff members told us that they had recently met with the registered manager to discuss their work. They said that such supervision sessions were happening more frequently than when we last visited. One staff member told us, "I was due a supervision today but as you are here it will be slightly delayed." Another staff member said, "They are getting better. I've had two since the last Care Quality Commission inspection." Staff records showed us that staff had received a recent supervision. The registered manager told us that they had plans to make sure this became routine. We found that although supervisions were occurring, they were not always effective. For example, staff were reminded about placing individuals at the centre of the care and support offered to them. On occasion, we found that staff were not always doing this when offering people support with their meals or to move position.

People had mixed views on the food offered to them. One person told us, "It leaves a bit to be desired as it can be dried up and bland, not very exciting. The fish is often dried up and overcooked. They come every morning and offer a choice for lunch and tea. Jam, ham or a cheese sandwich and shop bought cake for tea. A most uninteresting meal. Once in a blue moon we get cheese on toast. They say we can ask for a snack at bedtime like toast or another sandwich." Another person said, "It could be better as we get too much of the same stuff. There is no variety. I can ask for toast or what I fancy before bed if I'm hungry." Other people were satisfied. One person told us, "I eat in my room and it's hot enough. I enjoy my meals and we get asked beforehand what we fancy." Another said, "I enjoy my meals so I can't complain. I don't like potatoes so leave them."

We found that there were no menus on display to advise people about what food was to be served. We spoke to a cook who told us, "We have meetings every so often. They will say what they [people] want and don't want. We are looking at tweaking the menu at the moment." They also said that there were plans to revise the menu but this had not yet occurred. We spoke with the registered manager about people's feedback about the food offered to them. They told us that suggestions were asked for during residents meetings and they would ensure this continued to happen and any changes needed would be made.

We saw that people's mealtime experience could be improved. We saw that there was little conversation between staff and people during this time. Staff often undertook their duties without speaking with people to check if they were satisfied with their meal. We saw food given to people without an explanation of what it was. On one occasion we heard a person say, "Can I have a drop more gravy please?" A staff member did not respond immediately and when they returned with the gravy said, "Over potato?" and offered no other conversation. We gave feedback to the registered manager about our observations. They said they would speak with the staff members concerned about improvements needed to their practice.

Where there were concerns about people's eating and drinking, the recording in people's care records was not always sufficient to provide guidance to staff. Two people were assessed as being at risk of not having enough to eat. There was no guidance for staff to follow, or a record of action taken, to support the person to eat well. The registered manager told us this was a recording issue. They told us that they had sought the advice of one person's GP and there was no current need for further specialist assessment. For the other person the registered manager told us that they would make sure that staff had the guidance they required. They said they were confident staff were routinely prompting these people to eat sufficiently. They said they would make improvements to these people's care records.

Staff members knew what to do where there were concerns about people's eating and drinking. One staff member told us, "A few have been referred to dieticians. Some are on food and fluid charts so that we can check what they've eaten and drank." Another said, "We make adjustments to people's diets if required. For example, one person is having some difficulty swallowing so we offer softer choices." We saw that some people's care records contained information for staff to follow where people required additional assistance to make sure they had enough to eat and drink. For one person this included the need for staff to record what the person ate and drank every day so that staff could monitor this. We saw this to be in place. A relative told us that the provider took action where there were concerns about their family member. They said, "She's [person] lost quite a bit of weight over the months and now they weigh her weekly."

People were confident that their health care needs were met. One person told us, "The nurse comes in to check after I had some cream from the doctor. [Opticians] come in to check my eyes and I had some new glasses." A family member commented, "They soon get the doctor in if it's needed. She [person] has the chiropodist to see her, plus the optician came in." We saw within people's care records that they had access to health care services such as district nurse visits and to see their doctor where this was required. Staff recorded and followed actions that were required following appointments. This meant that people's healthcare needs were met.