Bole Aller House Limited

Bole Aller House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 10 and 15 March 2016. The inspection was a focused inspection to follow up on the breaches of regulation as a result of our inspection in October 2015. At our last inspection in October 2015, Bole Aller House was rated as 'requires improvement' with breaches regarding safe care and treatment, person-centred care, staffing and governance arrangements. The provider sent us an action plan setting out how they were going to make improvements. They said the actions would be completed by February 2016. The rating for this service has not changed as a result of this inspection.

Bole Aller House is situated in a rural area between Broadclyst and Cullompton. Accommodation is provided in two separate houses, plus a converted stable block and two self-contained bungalows. The home provides support and accommodation to people primarily with a mental health need, although people may also have a learning disability. A minibus and transport is available. Bole Aller House Ltd is a subsidiary of Allied Care Ltd.

There was not a registered manager in post at the time of our inspection. However, there was an acting manager from one of the organisation's sister home overseeing Bole Aller House. 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.

At our last inspection in October 2015 we found that people did not always receive their medicines as prescribed due to reoccurring medicine errors. At this inspection we found the provider had taken action to improve the handling of medicines and ensure that staff identified mistakes quickly. However, there had been two further mistakes when people had not received their medicines as prescribed for them. Written guidance was not available to support staff to give people some of their medicines in a safe and consistent way.

At our inspection in October 2015 we found people were not getting out as much as they would like due to both the staffing arrangements, including not having enough drivers available. This inspection found improvements had been made. Staffing levels had been increased which meant people were able to get out more and engage in meaningful activities to aid their general well-being. The service was in the process of revisiting care planning, Wellness Recovery Action Plans (WRAPs) and how to further increase activities.

At our inspection in October 2015 we found audits were completed on a regular basis as part of monitoring the service provided. However, problems remained with regard to staffing arrangements to meet people's specific activity needs, staff retention and morale and medicine errors had continued to occur. This inspection found improvements had been made. However, good practice suggestions had not been implemented by the time we spoke with the acting manager on 12 April 2016 for when required medicines and creams.

Prior to the inspection we had concerns raised by health professionals involved with the service. We therefore looked at people's nutrition and found people were offered a balanced and varied diet and health promotion was encouraged.

There were two breaches in regulation. You can see what action we took at the end of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Improvements had been made with the management of medicines. However, people did not always receive their medicines as prescribed.

Staffing levels had been increased which met the needs of the people using the service.

Is the service effective?

Good

The service was effective.

People were offered a balanced and varied diet and health promotion was encouraged.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were now able to engage in meaningful activities to aid their general well-being, although staff were looking to increase this further. Some progress was being made to look at each person's well-being as part of care planning. This work was not yet complete nor fully embedded at the service.

Is the service well-led?

Requires Improvement

The service was not always well-led

Good practice suggestions had not been implemented for when required medicines and creams. New polices had not been written when required to guide staff.

Bole Aller House

Detailed findings

Background to this inspection

We carried out an unannounced comprehensive inspection of this service on 27, 28 and 29 October 2015. The outcome was Bole Aller House was rated as 'requires improvement' with breaches of safe care and treatment, person-centred care, staffing and governance arrangements. As a result we undertook a focused inspection on 10 and 15 March 2016 to follow up on the breaches.

The inspection team consisted of one adult social care inspector and one pharmacy inspector.

Before the inspection, we reviewed the information we held about the home and notifications we had received. Notifications are forms completed by the organisation about certain events which affect people in their care. We also looked at their action plan submitted by the provider after our last inspection.

We spoke with nine people receiving a service and nine members of staff, which included the acting manager. We reviewed certain parts of five people's care files and carried out observations throughout our inspection. After our visit we sought feedback from health and social care professionals to obtain their views of the service provided to people and whether they felt improvements had been made. We received feedback from one health and social care professional. The service is currently in whole home safeguarding due to concerns raised by health and social care professionals about staffing levels and people's needs not being met. Professionals are working closely with the home to ensure the safety of people.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in October 2015 we found a breach of regulation 12 (1) and (2) (g). People did not always receive their medicines as prescribed due to reoccurring medicine errors. This placed people at risk of a deterioration in their physical or mental health. During this inspection we found that staff had taken action to address this but further improvements were needed.

Since our last inspection the provider had changed the pharmacy system used in the home to try and reduce the risk of mistakes occurring. Staff had received update medicine training from the pharmacy staff supplying medicines to the service. Senior staff were in the process of completing competency assessments to check that staff were following safe practice following the training. This helps to ensure staff will give people their medicines correctly. The day before our inspection pharmacy staff had been to the home to check on the arrangements for handling medicines. Staff told us they had received feedback from this and were waiting for a written report to help support improvements.

There were procedures in place for checking and administering medicines. One member of staff was responsible for giving people their medicines and signing the medicines administration record. A second member of staff was responsible for checking the medicines were given correctly. Staff had introduced checks of all the medicines supplied in standard packs at each of the four regular medicine times. This meant that staff would identify any mistakes very quickly.

In January 2016, there had been a mistake when staff had given one person the wrong dose of one of their medicines. We saw an error report following this error describing the action taken to make sure the person was safe. However there was no analysis of the cause of the mistake, to reduce the risk of it recurring. Two days before our inspection one person had missed a dose of antibiotic. Staff had identified these mistakes very quickly because of the systems in place.

Some people were prescribed medicines to be given 'when required', for example for pain relief or to treat anxiety or agitation. The home's medicines policy stated that there should be guidelines in place to evidence when staff should give people these medicines. We found that staff were able to describe when they would give people these medicines but there were no written guidelines in place. We also checked one person's care plan relating to behaviour but found there was no information to support staff with the appropriate use of medicines prescribed 'when required'. This increased the risk that people may not receive these medicines in a safe and consistent way.

Some people were prescribed creams and ointments to be applied by care staff. Staff were able to describe where they would apply the various creams. However this information was not always available with the medicines charts or in people's care plans. Staff told us their pharmacy had also highlighted this and had suggested some separate record sheets they could use to help address this.

This was a breach of Regulation 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

Medicines were stored safely and securely. Staff giving some people their lunch time medicines used safe practice. Staff described how people liked to be given their medicines and followed this in practice. There was no written guidance about people's individual wishes with their medicines administration records. However, the manager showed us an example of a new care plan, which included this information. People we spoke to did not have any concerns with how staff looked after their medicines and said their medicines were always available for them. One person said staff were meticulous with their checks as they were giving medicines.

At our inspection in October 2015 we found there were insufficient staffing numbers to ensure people were engaged in meaningful activities. This inspection found improvements had been made. One person commented: "There are enough staff to keep me safe."

The organisation had raised staffing numbers from three care staff to six during the daytime. The cook's hours had also been increased and now provided weekend input. A member of the maintenance team's hours had been increased with them having responsibility of cleaning the converted stable block. This enabled care staff to be freed up to spend meaningful time with people for activities. Where shifts needed to be covered, the service was using agency staff from one provider to ensure consistency as a far as possible. Staff comments included: "Things are much better now. Less staff sickness and people are turning up for work"; "There are six support staff on shift now, which has really helped"; "Things are better here now, there is more staff and people are working as a team"; "Things are much better here. We still need to recruit more staff, but people are getting out more" and "People and staff are happier. The management team are being supportive and things are changing for the better. We still need to recruit more staff, but the increased staffing levels have helped things to improve." People were in the process of being reviewed by their funding authorities. Part of these reviews were to look at the hours people were funded for to ensure they were receiving the support they needed to maintain their physical and mental health well-being.

Good

Is the service effective?

Our findings

We looked at people's diet and nutrition due to concerns raised by other professionals involved in the service. We found people were offered a balanced and varied diet and health promotion was encouraged.

The service was working with health professionals when there had been a noticeable change in people's weights. For example, where a person had lost weight they were now receiving supplementary drinks and their weight was being closely monitored. Another person received one to one support at mealtimes and their food and fluid intake was being recorded. People had been assessed by the speech and language therapist team and staff were following their advice. Speech and language therapists work closely with people who have various levels of speech, language and communication problems, and with those who have swallowing, drinking or eating difficulties. Where people had put on weight they were being encouraged to eat healthily and exercise. For example, one person attended a slimming group and another person was in the process of joining a gym. Care plans and staff guidance emphasised the importance of people having a balanced and nutritious diet to maintain their general well-being. In addition, diet and nutrition training for staff had been arranged for May 2016.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in October 2015 we found people were not getting out as much as they would like due to both the staffing arrangements and not having enough drivers available. This inspection found improvements had been made. Having enough drivers remained a problem. However, the provider was now paying for a local taxi service so people could get out in the local community. People commented: "I go out shopping, walking and to church"; "I do baking and have my nails done"; "I went to the pub last night and had crisps"; "I go out quite a bit, work and shopping"; "I went to Tesco the other day"; "Going out tomorrow to the seaside"; "I chose to stay at home" and "I am going to the bank and shopping this afternoon."

We found people preferred going out for meals and shopping. One staff member commented: "People tend to like to go shopping. Prefer to go out rather than in-house activities. We can order taxis now, which have helped." We discussed with members of the management team what their plans were to develop the activities on offer to people to aid their general well-being. They explained a team leader was in the process of increasing in-house activities and the staff team were always looking for ways to encourage people to engage in other activities. One person was going to art therapy and another was in the process of joining a gym. A staff member said, "We are doing more in-house activities. Bingo, movie nights and naming games." Another staff member said, "X was feeling low the other day. I took them out and we took some photos. Their mood lifted."

Revised care plans were being formulated with people and the service was also working with health and social care professionals to develop, 'Wellness Recovery Action Plans' (WRAPs), for people to aid their mental health. WRAP is a self-management plan, people develop to maximise their personal wellness. Part of the plan looks at meaningful activity to aid well-being. Three people were in the process of developing their own WRAPs with support from staff.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in October 2015 we found audits were completed on a regular basis as part of monitoring the service provided. However, there continued to be problems with staffing arrangements to meet people's specific activity needs, staff retention and morale and medicine errors had continued to occur. This inspection found improvements had been made. For example, staffing levels had been increased to enable people to engage in meaningful activities.

However, good practice suggestions had not been implemented by the time we spoke with the acting manager on 12 April 2016. For example, written guidance for when required medicines and creams. These guides would enable staff to be consistent when administering people's medicines.

This was a breach of Regulation 17 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive their medicines as prescribed. Written guidance was not available to support staff to give people some of their medicines in a safe and consistent way. Regulation 12 (1) and (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not acted on external advice about the implementation of written guidance for staff to follow when administering medicines. Regulation 17 (2) (a) (b)