MacIntyre Care

Beulah House

Inspection Report

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Date of inspection visit: 08/04/2014
Date of publication: 07/09/2014

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Summary of findings

Overall summary

Beulah House provides care and support for up to five people who have a learning disability. Five people were using the service at the time of our inspection.

The service had a manager in place who had been registered with us since May 2011. This meant there was a named and registered person who was responsible for the management of the service.

Some systems were in place to assess and manage the risks posed to people who used the service and the staff understood their responsibilities to ensure people were cared for safely. Improvements were required to ensure these systems were effective at protecting people from the risks associated with their medicines. You can see what action we told the provider to take at the back of this report.

Staff understood the needs of the people who used the service. Systems were in place to ensure that care records contained the information staff needed to provide care that was based upon each person's personal preferences. However, this information was not always stored securely which meant there was a risk this could be lost or destroyed.

Care was provided with kindness and compassion by staff who were appropriately trained and skilled. People and their families told us they were happy with the care and support provided.

Some people who used the service did not have the ability to make decisions about some parts of their care and support. Staff had an understanding of the procedures in place to protect people who could not make decisions about their care, support and safety. These procedures followed the legal requirements outlined in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). This legislation sets requirements to ensure that where appropriate decisions are made in people's best interests.

The home promoted an inclusive culture. People were involved in making choices and decisions about their care and their choices and decisions were respected by the staff. People's independence was also promoted.

We saw some examples of care that was based on best practice. The registered manager assessed and monitored the quality of some aspects of the care provided so that improvements could be made.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Staff had received training in how to identify and report possible abuse.

Procedures were in place to identify and manage individual risks such as; behaviours that challenged. Staff were aware of the risks to people and they understood how to manage these risks.

Effective systems were not in place to ensure that medicines were managed safely. We saw that medicines were not always stored securely and guidance outlining when to administer people's medicines was not always available.

Information about people who used the service was not always kept safe. This meant there was a risk that this information could be lost or destroyed.

Procedures were in place to ensure the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were followed. This meant people could be assured decisions would be made in their best interest if they did not have the ability to make decisions for themselves.

Are services effective?

Staff communicated effectively with the people who used the service. This better enabled them to understand and meet people's care preferences and choices

Involvement from advocates could be requested if a person was unable to express their wishes and views.

People received care and support from staff who had the appropriate knowledge and skills. Arrangements were in place to request heath, social and medical support when needed.

Are services caring?

People and their families told us they were happy with the care they received and we saw that care was provided with kindness and compassion.

People were treated with dignity and respect and individuals could access private areas within the home environment as required.

Systems were in place to handover important information about the care and support people needed if they required care and treatment from other providers or services.

Summary of findings

A new initiative was being implemented to enable staff to reflect on and develop their interactions with the people who used the service.

Are services responsive to people's needs?

Staff understood how each person communicated and systems were in place to promote the involvement of people in their care.

People were enabled to make choices and decisions about their care. The relevant legal guidance was followed to support people to make decisions when they were unable to do this alone.

Staff enabled people to access their preferred activities within the community.

The provider listened to and acted upon feedback received from people and their families. This resulted in improvements to the way people received their care.

Are services well-led?

There was a positive and inclusive culture within the home. We saw that people who used the services were treated by the staff as equals.

Staff told us they felt well supported and they were included in the planning of service improvement.

Reported incidents were monitored by the registered manager so that risks of further incidents were reduced.

Systems were in place to ensure that the numbers and skills of the staff enabled people's preferences and care needs to be met.

The registered manager assessed and monitored the quality of some parts of the care so that improvements could be made.

The registered manager used some best practice evidence to improve the quality of care and support. We saw examples of some care and support that was based upon best practice evidence.

Summary of findings

What people who use the service and those that matter to them say

On the day of our inspection five people were using the service. Some of the people were unable to verbally express their views about their care with us. Two people chose to speak with us. They told us they were happy with the care they received. One person said, “This place is great”. Another person said, “This is my house, I like it”.

We spoke with the relatives of two people who used the service. They also told us they were happy with the care provided. They said, “The staff take a keen interest in everybody’s care and welfare”. Another relative said, “Everything is focussed upon making life better for my relative”.

People and their relatives told us the staff at the home were friendly and welcoming. One relative said, “We feel they are part of the family, and so do we when we visit”.

People and their relatives told us the staff promoted their freedom to make choices and participate in tasks and activities that were based on people’s individual preferences. One relative said, “X (my relative) can do what they want”.

Beulah House

Detailed findings

Background to this inspection

We inspected Beulah House on 8 April 2014. This was an unannounced inspection which meant the staff and provider did not know we would be visiting.

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave One.

The inspection was led by an inspector for adult social care and we were accompanied by an expert by experience who had personal experience of caring for people with a learning disability.

Before we inspected the service we checked the information we held about the service and the provider. We saw that no concerns had been raised and the service met the Regulations we inspected against at their last inspection on 15 November 2013.

During our inspection we informally observed how the staff interacted with the people who used the service. We also observed how people were supported during their lunch and during individual tasks and activities.

We spent time with all five people used the service, but only two of the people who used the service verbally communicated their thoughts about their care to us. We also spoke with the relatives of two people who used the service, the registered manager and four other members of care staff.

We also looked at two people's care records to see if their records were accurate and up to date.

Are services safe?

Our findings

Procedures were in place to ensure any concerns about people's safety were appropriately reported. All the staff we spoke with told us how they would recognise and report abuse. Staff told us and training records confirmed that staff received training to ensure they were up to date with the procedures in place to report safety concerns.

People's risks were appropriately assessed, managed and reviewed. We looked at the care records of two people who used the service. Up to date risk assessments were present in each care record. These assessments were different for each individual as they reflected each individual's specific risks. Where risks had been identified, management plans were in place and staff demonstrated they knew how to keep people safe. We saw that people's care records were not stored securely within the home. This meant that there was a risk that information about people's care needs could be lost or misused. Improvements were required so that people could be assured that their personal information was stored securely.

Where appropriate the staff involved people and their families in the risk assessment process. Relatives we spoke with gave us examples of how risks associated with their relatives care had been communicated with them. One relative told us about changes that had been made to reduce the risk of injury in the event of a fall. Another relative told us how the staff checked to see that people's personal furniture met fire safety standards.

We saw that the risks to each person's safety and welfare had been considered for their care at home and within the local community. For example, we saw that staff had considered the risks associated with using different types of transport.

Some people who used the service displayed behaviours that challenged. We saw that the triggers for people's individual behaviours had been identified and plans were in place to prevent or manage these behaviours. These plans included people's individual care preferences and focussed on promoting people's dignity and privacy during episodes of behaviours that challenged. The staff we spoke with confirmed they understood these plans as they were able to tell us about people's individual triggers and management plans.

Some people who used the service did not have the ability to make decisions about some parts of their care and support. Staff had an understanding of the procedures in place to protect people who could not make decisions about their care, support and safety. These procedures followed the legal requirements outlined in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). This legislation sets requirements to ensure that where appropriate decisions are made in people's best interests. We saw that staff had received training in the Act and the DoLS and staff told us about the local systems in place to protect people's rights.

Effective systems were not in place to ensure people were protected from the risks associated with medicines. This meant there had been a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The evidence below describes how this Regulation had been breached.

Locked cupboards were located within each person's bedroom that were dedicated to the storage of medicines. We saw that people's medicines were not always stored securely within these cupboards. For example, we saw that one person's prescribed cream was stored on the top of a table that was in clear view when we stood in the reception area of the home. This meant there was a risk that people could access or use this medicine in an unsafe or unsupervised manner.

There was no effective system in place to enable the staff to account for the numbers of medicines stored at the service. We saw that stock sheets were kept, but these did not reflect an accurate account of the numbers of people's medicines. This meant that staff could not confirm that people had received the correct amount of their medicines as prescribed.

Some people who used the service needed their medicines to be administered on an 'as required' basis. Staff did not have access to guidance that outlined when people should receive their 'as required' medicines. We looked at three 'as required' medicines. These included an anti-sickness medicine, an anti-diarrheal medicine and a pain relieving medicine. We asked three staff members when they would administer these medicines. All three staff told us when they would administer the pain relief medicine, but none of

Are services safe?

the staff were able to tell us when they would administer the other two medicines as they were not familiar with their uses. This meant that people were at risk of not receiving their prescribed medicine at the time they required it.

We noticed that one person's 'as required' pain relief was three months past its expiry date. This meant that there was no effective system in protect people from receiving an ineffective or unsafe medicine.

People's medication administration records were not stored securely in their bedrooms. This meant there was a risk that information about people's medicines could be lost and not be readily available in the event of an emergency.

Are services effective?

(for example, treatment is effective)

Our findings

Staff told us they involved people and their relatives in planning and reviewing their care. This enabled the staff to identify people's preferences. One staff member said, "We do this much better now. I have sat down with X (person who used the service) in his room and we have talked about what he has done, what he's happy with and what he wants to do again". Relatives we spoke with confirmed that they were involved in this process. One relative said, "We are always included wherever possible". Staff could also request the support of an advocate on behalf of the people who used the service to represent the views and wishes of people if this was required.

Some people who used the service were unable to communicate verbally. Staff demonstrated they had the required skills to involve these people in the planning and reviewing of their care. Every person who used the service had a communication profile in place that described their methods of communication. This included interpretation of behaviours and body language. One staff member said, "X may not be able to talk to us, but we are very observant of their behaviour. X will growl or push away if he doesn't like something and when he is happy with something, he laughs and you can see it in his eyes".

We saw that communication dictionaries were in place for people who could communicate verbally. These dictionaries contained words used by the people and their intended meaning. For example we saw that one person used the word bike, but they used this to describe their mobility aid. This meant that staff had the information required to understand people's individual communication styles.

Care records contained up to date plans that were personal to each individual. These plans outlined the likes, dislikes and preferences of person and the staff we spoke with were aware of each individual's preferences. We saw that people's individual care needs and preferences were met.

For example, one person's care records recorded that they enjoyed participating in craft activities. We saw the staff successfully engage this person in a craft activity of the person's choosing when they showed signs of being restless. People and their families confirmed that individual needs and preferences were met. One relative said, "X can do what they want".

Staff told us that they used 'person centred planning' (PCP) to ensure care was personalised. Person centred planning is an approach used to assist people to plan their life and the support they require. One staff member said, "Since we have moved to PCP care has been more organised and outcomes for people are better". Another staff member said, "Some staff have been identified as PCP experts. That means they will get extra training and they will be able to advise us on how to be more person centred".

The staff were trained to provide the care and support people required. All the staff regular training which included; safeguarding people, moving and handling, first aid, epilepsy and managing behaviour that challenged. Staff told us they were happy with the training they had completed. One staff member told us, "The training here is tailored for the people who live here so it's all relevant".

Assessment and monitoring tools were used to enable the staff to identify changes in people's health and wellbeing. For example we saw that one person's blood sugars were monitored on a regular basis and staff understood the action they needed to take if the person's blood sugar levels were outside of the agreed range.

There was access to appropriate health, social and medical support. We saw that people were taken to see their GP promptly when they became unwell or their condition had changed. For example we saw that professional advice was sought when changes had been identified with people's continence or mobility. On the day of our inspection one person who used the service became unwell. Staff monitored this person closely and contacted the person's doctor when their condition deteriorated.

Are services caring?

Our findings

People and their families told us they were happy with the care and support provided. One person said, “This place is great”. The relative of one person said, “The staff take a keen interest in everybody’s care and welfare” and, “We feel they are part of the family, and so do we when we visit”.

We saw that people were supported with care and compassion. For example we observed one person being comforted by staff when they became upset. We saw the staff immediately respond to the person in a calming and reassuring manner which the person responded positively to.

We observed staff treating people with dignity. For example we saw that the staff dined alongside the people who used the service at mealtimes and staff engaged people in relevant and meaningful conversation. We saw that staff offered people an apron to wear to protect their clothing during their meal. One staff member wore an apron while they were eating their meal so that people were not made to feel different because they chose to wear an apron.

We saw the staff respected the people who used the service. People were encouraged to make choices for themselves and the choices people made were respected. We saw people were given a choice of meal at lunch time. One person chose an alternative option as they did not like the choices offered. We saw that the staff supported this person to receive their chosen meal. One staff member said, “People have their own preferences. I’m just here to support them with their chosen preferences”.

People care plans were focussed upon promoting independence and community involvement. We saw that people’s independence was promoted. One person chose to dry their hair in a communal area of the home. We saw a member of staff support this person to participate in this task as much as practically possible. We also saw one person participate in the preparation of their lunch. They were encouraged to participate in a fun and safe manner. The staff member said, “You can tell X enjoyed cooking today because of their smile. You can see the kitchen is in a bit of a mess now, but the mess doesn’t matter. What matters is they did what they could, how they could”.

People’s privacy was promoted. We saw that people could spend time alone in their bedrooms if they wished and we saw that personal care was provided in private areas of the home.

There were systems in place to provide other professionals or providers with the information required to meet people’s needs and preferences in the event that care or treatment needed to be given by staff from another service. Each person had an emergency folder that contained essential information about their care needs, communication methods and medicines. During our inspection one person required an emergency hospital admission. We saw that staff had this information ready to handover to the hospital staff.

The registered manager told us about a new initiative that was in the process of being implemented with the staff at the home. This was called ‘My key to developing facilitation skills’ and was aimed at assisting staff to reflect on their interaction skills with the people they support. The registered manager said, “Each staff member will have to complete one or two reflections each month using this tool. They will rate their communication skills and identify what they need to improve on. It will also reassure staff about what parts of communication they do well. This meant that a system was in place to enable staff to reflect on and develop their interactions with the people who used the service. We saw that this initiative had recently won a skills for care award in the ‘most effective new approach to service delivery' category. Skills for care awards recognise outstanding care from providers working in social care.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We saw that systems were in place to identify the support people required to make choices and decisions about their care. These systems followed the requirements of the Mental Capacity Act 2005. One staff member told us, "You always assume people have the capacity to make a decision, but it depends on what the decision is. If it's something major like an operation, we would have to involve other people to make sure it's the right decision". People's care records contained plans that outlined the types of decisions people could make by themselves and the types of decisions that needed to be made with the support of others. We saw that the where support was required, information was recorded that detailed who needed to be involved in the decision making process.

We saw that people who used the service were supported to express their views and be involved in making decisions about their care. One person told us they had been involved in choosing and purchasing new curtains for their bedroom. We saw people being offered choices about the food they ate, the personal care they received and the activities they participated in. Staff respected the decisions people made. One staff member said, "I always listen to and respect people's choices".

Information was presented to people in a manner that reflected their communication needs and their ability to understand. For example pictures of food were used to enable people to make choices about the food they ate. The staff showed us an information folder which contained easy read information on topics relating to health and social care, such as; going to the dentist. Staff told us they would use this information to help people understand their care.

We saw that the staff had the knowledge required to meet people's needs and interpret people's behaviours. This was because they understood the information contained within people's care records. We saw staff members effectively interpreting people's behaviours to respond to their needs in accordance with people's support plans. For example we saw one staff member respond promptly to one person's behaviour that indicated they wanted to change their clothing.

People were able to maintain their relationships with their family and friends. People told us they could see or speak to their families and friends at any time. Relatives we spoke with confirmed this. Where people did not have a family support network, the home acted appropriately to build up a 'circle of support' for the person. This included the use of advocates.

People were protected from the risks of social isolation. We saw that people were assisted to be involved in community based activities based upon their individual preferences. On the day of our inspection one person who enjoyed sports activities was enabled to access a community based exercise session. Another person who used the service excitedly told us about a trip to Euro Disney which they were planning with the staff.

We saw that people could participate in their preferred activities through positive risk management. For example, we saw that one person required their food to be pureed so they could swallow it safely. Staff ensured that this person could still eat at local restaurants by communicating the person's needs with the restaurant staff in advance.

People who used the service were asked for their feedback about the care. This was done on a one to one basis during care reviews. People that were unable to verbally communicate were involved in reviews of their care through the use of a scrapbook. The scrapbooks contained photos and descriptions of activities people had participated in each month. People updated their scrapbooks with the staff and the staff asked them what they had enjoyed and what they would like to again.

We saw that people's feedback was acted upon. For example one person told staff they did not like having their care review in a certain area of the home, so an agreement was made that their care review could be held in their bedroom.

We saw that people were supported to raise concerns about their care. A copy of the homes easy read complaints procedure was on display in a communal area in the home. People who used the service were unable to tell us if they understood this procedure, but one person told us they would, "tell the staff off" if they were unhappy with their care. Another person with the support of a staff member told us how they had been assisted to complain about the care they received from another service after receiving unsatisfactory care.

Are services well-led?

Our findings

There was a positive and inclusive culture at the home. One staff member said, "We are like a family here. We eat with the residents and we treat everyone the same". We saw that staff were made aware of the homes values and philosophy through their induction programme and training.

All the staff we spoke with told us they felt supported and enjoyed their work. One staff member said, "I love this job. The staff and service users are nice to work with and our manager is very approachable". Another staff member said, "We get regular supervision with our manager and we can go to her at any time". We saw that staff received regular supervision and appraisals.

Staff understood their right to share any concerns about the care at the home. All the staff we spoke with were aware of the provider's whistleblowing policy and they told us they would confidently report any concerns in accordance with the policy.

The provider sought feedback from the staff through a staff survey. The registered manager told us that changes had been made in response to feedback gained from the staff. An example of this was staff had raised concerns that they were unable to take regular breaks. The manager therefore reminded the staff about the procedures in place that supported them to take breaks. A staff wellbeing risk assessment had also been completed to assess and manage the risks to the staff's wellbeing while they were at work.

There was a clear management structure at the home and within the organisation. The staff we spoke with knew who their line manager and area manager was. We saw there were systems were in place to monitor the quality of the care provided. Audits of staff appraisals, the environment and infection control procedures were completed. These audits were evaluated and where required action plans were in place to drive improvements. However, the provider needs to ensure that a system is in place to monitor how medicines are managed and how care records are stored within the home.

We saw that staff were involved in service improvement planning. The staff told us they had been involved in a service development day. Minutes of the development day showed that staff had shared what they thought had worked well and what required improvement. Staff had highlighted that they struggled to get all their jobs done, so with the support of the registered manager, individual staff roles had been identified and assigned, so tasks were evenly distributed to make them more manageable.

We saw that effective procedures were in place to ensure the staffing numbers and skill mix were sufficient to keep people safe. Staff told us that staffing numbers enabled them to meet people's individual needs. The registered manager told us that staffing numbers were flexible to enable people to attend appointments and participate in their preferred activities. Rotas demonstrated that additional staff were used to facilitate activities such as swimming and disco's.

We saw that reported incidents were monitored and investigated appropriately and action was taken to reduce the risk of further incidents. Staff told us they were always made aware of any changes that had been implemented in response to incidents.

We saw there was an effective complaints system in place to enable improvements to be made. We saw that the registered manager responded appropriately to complaints.

The care at the home was based upon best practice. Systems were in place to ensure information was provided to people to enable them to be involved in their care. For example, care records contained pictorial prompts to help people to understand their support plans and pictorial outcomes boards were located in each person's bedroom. These pictorial boards were used to display what each person had achieved every month.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Regulation 13 The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. People were not protected from the risks associated with medicines because effective systems were not in place to ensure medicines were stored and administered safely. Regulation 13

Regulated activity	Regulation
	The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Regulation 20 (2) The registered person must ensure that the records referred to in paragraph (1) (which may be in electronic form) are – Care records and medication administration records were not kept securely. Regulation 20 (2)(a) 1. Kept securely and can be located promptly when required