Cooper Residential Homes Limited

Bethel/Bethesda Residential Home

Inspection report

Equity Road East
Earl Shilton
Leicestershire
LE9 7FY
Tel: 01455 847505
Website: www.bethel-bethseda.co.uk

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Ratings

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

Overall summary

We inspected the service on 12 November 2014. The inspection was unannounced.

Our previous inspection was on 4 March 2014 when we found that the service was meeting the essential standards we inspected.

Bethel / Bethesda is a residential care home that provides accommodation for up to 34 elderly people who require personal or nursing care, but nursing care is not provided. At the time of our inspection 24 people used the service.

It is a condition of registration for the service that it is managed by a person who is a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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. At the time of our inspection the registered manager had been absent for more than 28 days. The absence began in June 2014.

The provider's arrangements for the management of the service pending the registered manager's return were effective, but aspects of the arrangements for monitoring and assessing the service required improvement.

People we talked with spoke positively about the service. People who used the service and relatives told us it was a safe home. Staff we spoke with knew how to keep people safe. Staff knew how to identify signs of abuse and how to report it. They were confident that any concerns they raised with the acting managers or the owner would be taken seriously and investigated. Staff also knew how they could raise concerns about people's safety and welfare with the local authority, the police and the Care Quality Commission.

People's plans of care included risk assessments of activities associated with their support routines and risks associated with their limited mobility. The use of mobility equipment had been risk assessed to ensure that staff used the equipment safely. Other risk assessments included guidance about how to support people with personal care.

Staffing levels were based on people's dependency levels. This meant that more staff could be on duty if people's needs increased. The provider had effective recruitment procedures. The recruitment procedures had ensured as far as possible that only people suited to work at the service were recruited.

People received their medicines when they needed them. The service had arrangements for the safe management of medicines.

People's plans of care were individualised and contained information about people's assessed needs and how those needs should be met. The plans included people's life histories and details of their likes and dislikes. Staff we spoke with had a good knowledge of people's needs. Staff acquired their knowledge from talking with people. People told us their needs were met and that staff were attentive and quick to respond to calls for assistance.

People who used the service felt that staff understood their needs. The training staff received helped them provide care and support to the people who used the service.

Staff were aware of the relevance of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). This is legislation that protects people who are not able to consent to care and support, and protects them from unlawful restrictions of their freedom and liberty. No person was under a DoLS authorisation.

People's nutritional needs were met. People liked the food the service provided and that they had a good choice of food. Staff ensured that people had enough to drink throughout the day and people had drinks available in their rooms at night.

People had access to healthcare services. Delivery of care reflected the advice and guidance provided by healthcare professionals, for example doctors and nurses.

Staff supported people with kindness and care. People expressed their views about their care and support when they spoke with staff and at `residents meetings'. Relatives had also attended those meetings. People's privacy and dignity were respected. People's rooms were personalised with family photographs and belongings. That had contributed to people's sense of comfort and independence.

People told us they knew how to raise concerns and that they were confident they'd be listened to.

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 safe.

People were protected from abuse and avoidable harm. Staff understood risks associated with people's care and supported people accordingly.

The provider employed enough suitably experienced staff supported people using the service.

People received their medicines when they needed them.

Good

Is the service effective?
The service was effective.

Staff were trained to be able to provide care and support to the people using the service

Staff had awareness of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were supported with their dietary and health needs.

Good

Is the service caring?
The service was caring.

Staff showed kindness and compassion when they supported people. Staff respected people's privacy, dignity and independence. People were encouraged to do as much for themselves as possible.

Good

Is the service responsive?
The service was responsive.

People received care and support that met their individual needs.

People were supported to maintain their hobbies and interests through activities that were meaningful to them.

People knew how to raise concerns and were confident they'd be listened to.

Good

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

Interim arrangements for covering the absence of the registered manager were effective.

The service's arrangements for monitoring and assessing the service did not promote improvement.

Requires Improvement

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.

The inspection took place on 12 November 2014. The inspection was unannounced.

The inspection team consisted of two inspectors. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority who had funding responsibility for some of the people who were using the service.

We spoke with seven people who used the service and a relative of one of those people. We asked them for their views and their experience about the service. We also spoke with the two interim managers, the provider and five care workers. We looked at the care records of four people who used the service and other documentation about how the home was managed. This included policies and procedures, records of staff training and records associated quality assurance processes. We spoke with a chiropodist who visits the service and the medical practice that provides doctors' visits to the home. We also spoke with a dietician who visited the service and the pharmacist who supplied medicines to the service.

Is the service safe?

Our findings

People who used the service told us they felt safe. A person told us, "I feel safe here. I wouldn't want to be back in my house." Another person told us, "I feel safer here than anywhere else." People told us they felt safe because staff made sure they were comfortable when they were in their rooms. Staff we spoke with told us that they routinely checked people who were in their rooms to see they were comfortable. Records we looked at confirmed those observations had been made.

The provider had procedures for safeguarding people using the service. Staff knew how to recognise, respond to and report abuse. Staff knew they could raise any safeguarding concerns directly with the local authority and the Care Quality Commission. People using the service and their relatives told us they knew how they could raise any concerns about their safety and welfare.

People's plans of care included risk assessments of activities associated with people's care and support. For example, some people required assistance with personal care or their mobility. Those people's plans of care included risk assessments that informed staff how they should support people with those aspects of care safely and in a way that protected people from injury.

When staff supported people they gave people choice. A person who used the service told us, "They help me to do things [like washing and dressing], but they encourage me to do things myself." Other people told us that staff supported them with most things and that they felt safe when staff used equipment to lift and transfer them. People had personalised slings that were used with lifting equipment which minimised any discomfort to people when they were hoisted and transferred.

Staffing levels were based on people's needs. Staffing levels had not reduced despite there being fewer people using the service. In practice this meant that there were always a minimum of five staff providing care and support to 24 people during the day and three staff at night-time through to morning. People who used the service told us they felt enough staff were on duty. A person told us, "Staff come quickly when I use the call alarm."

The provider had effective recruitment procedures. New staff had not been allowed to start work until a series of pre-employment checks had been carried out. The provider had followed disciplinary procedures when appropriate. This meant that people who used the service could be confident that the provider ensured as far as possible that only people who were suitable to work at the service did so.

We looked at the arrangements for the safe management of medicines. Only staff that had been trained to administer medicines did so. We saw that routine medicines were dispensed mostly from blister packs that were made up by the pharmacy that supplied the service with prescribed medicines. This helped to ensure that the right medicines were given to the right people at the right time. The pharmacy provided Medication Administration Record (MAR) sheets. These MAR sheets had the person's photograph and details to help identify them, any allergies were listed. Times for the medication were clearly printed. These arrangements reduced the risk of medication errors being made. 'As required' medicines (PRN medications) are prescribed to be given when a person needs them, for example for pain relief or to reduce anxiety. When staff gave people PRNs the reasons for doing so were recorded. This meant that PRNs were given as prescribed.

The provider had a policy for dealing with medical emergencies. The procedure required staff to telephone for an ambulance then a doctor. However, staff we spoke with made told us they had made calls the other way round. After we brought that to the provider's attention they reminded staff about the correct action to take in an emergency.

Is the service effective?

Our findings

People who used the service spoke in complimentary terms about the staff. A person told us, "On the whole they [staff] are pretty good." People told us that staff supported them to live their lives the way they wanted. A person told us. "I want to be independent. They [staff] help me be independent." They added, "I choose when to get up and when to have a shower. The staff help me do that." Their relative confirmed what they told us. A health professional who made regular visits to the service told us, "They [the service] have some extremely good carers, some are brilliant. It would be difficult to find fault with them."

We talked to care workers about how they developed knowledge about the needs of people they supported. They told us that their training had helped them support the people who used the service. A care worker's comment was representative of what others told us. They said, "The training has equipped us to the job, very much so." The staff we spoke with had a good understanding of people's needs and preferences about how they wanted to be supported. Staff knew about people's dependency levels and people's likes and dislikes. A person using the service told us, "I get the care I want." Staff told us that most of their knowledge about people came from speaking with them other care workers and handover meetings and notes. A care worker told us that they used their knowledge of people "to give the best care we can." We observed a staff handover meeting. We saw that staff communicated effectively and shared important information.

During a handover meeting care workers were given lots of information about people who used the service. Information was given about people's health, mood, things they had done and things people had asked for. The information was given verbally by senior care workers. After the meeting we asked care workers about what they had been told and all had an accurate recollection. That showed that staff communicated effectively with each other and shared relevant information about people who used the service.

At the time of our inspection one senior care worker had received training about the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). This is legislation that protects people who are not able to consent to care and support, and protects them from unlawful restrictions of their freedom and liberty. There were plans for that senior to train other staff about MCA and DoLS. Care staff we spoke with had an awareness of MCA and DoLS. They knew they had to seek a person's consent before providing care and understood that no forms of restraint could be used unless it had been authorised.

People's plans of care included details of their nutritional needs and their food preferences. That information was shared with cooks who prepared people's meals. Cooks had information about people's individual food preferences, food allergies and specific medical dietary needs and their meals were prepared accordingly. People were able to choose from a variety of options of what to have at breakfast and main meal times. Comments from three people included, "The food is very good", "The food is good, you get a choice" and "We get a choice for all meals. I'm diabetic, the food I have is appropriate."

People who required help with eating their meals received appropriate support from staff. We observed the lunch time meal. The meal time had a pleasant atmosphere was pleasant and people clearly enjoyed their meals. They ate their meals at a pace that suited them. People enjoyed conversations with other people and staff during their meal.

People were able to have snacks when they wanted. They had regular refreshments. Fresh fruit was available. We saw people having fruit. This showed that staff encouraged people to have a healthy and balanced diet.

Staff kept records of how much people ate and drank. This made it possible for staff to monitor people's food and fluid intake. When required, the provider had sought and acted upon advice from a dietician who visited the service. Referrals to diabetes clinics and dieticians had been made when this was required.

People were supported to maintain their health. People who needed them had special profiling beds to help prevent pressure ulcers developing. The service had arranged for people to receive care from healthcare professionals. We saw that a person's plan of care had been updated to reflect advice and recommendations following treatment they had in hospital.

Is the service caring?

Our findings

People and their relatives had been involved in the assessments of their needs and discussions about how they wanted to be supported. A person using the service told us they had told staff how they wanted to be supported and said, "I get the care I want." People using told us that staff showed kindness and compassion. A person told us, "We only have to ask for something and we get it." Another person told us, "Everyone is very helpful, you only have to ask." People and relatives we spoke with told us that they knew what care and support they should receive. . . People using the service had regular dialogue with staff who supported people to express their views about their care and support. People told us they attended residents meetings and felt informed about what was happening at the service. A person told us, "It feels like it's my home."

Five care workers we spoke with told us that they had learnt about people needs and preferences from talking with people and their relatives. Care workers displayed a detailed knowledge about people's likes, dislikes and dependencies. For example, a care worker we spoke with knew what people's favourite clothes were, what they liked having conversations about and their hobbies and interests. A person using the service told us, "All the staff are nice. I can talk to any of them." People told us that staff respected their choices and preferences. A person told us, "I choose when I get up and when I to have a shower."

Staff interacted with people in a meaningful way. For example, when they supported or assisted people they explained what they were doing and involved people. At lunch time we saw care workers provided support in a caring manner. Throughout our inspection care workers showed an interest in people's wellbeing. They asked people how they felt and whether they were comfortable. What people told us about staff and what we saw showed that staff had developed caring relationships with people who used the service.

Information about how people could access independent advocacy services was on display on information boards. People and relatives we spoke with knew how they could access advocacy services if they needed to.

The provider promoted people's privacy, dignity and respect through its policies and procedures and staff training and staff who were `dignity champions'. People using the service told us staff were polite. One said, "Staff are polite, it makes for a happy atmosphere. "We saw that staff knocked on people's doors and waiting to be invited in before entering people's rooms. Staff spoke politely with people and addressed them by their preferred name. When staff spoke about people, for example during a handover meeting, they did so in a respectful way. People were able to spend time in their rooms when they wanted and they received visits from relatives in their rooms. There were no undue restrictions on relatives visiting times.

Information about people who used the service was kept confidential and was securely stored so that their personal details and information were protected. The service had arrangements for ensuring that information about people was shared only with relatives that people wanted that information shared with.

Is the service responsive?

Our findings

When we asked people about the care and support they received their responses included, "I get the care I want", "I'm well looked after" and "The girls are there for you if you want them." A relative told us, "My mother has told me that she gets the care she expects."

People and their relatives had been involved in discussions about their care and support. They told us they had been asked for their views. This had mainly been through dialogue with staff. Staff we spoke with told us they regularly spoke with people to ensure people were well and receiving appropriate care and support. People's plans of care included information about how they wanted to receive their care and support. The plans included information about people's likes and dislikes. Information about people's hobbies and interests was easy to find in a section of the plans headed `things I find enjoyable, meaningful and important'. Plans of care were reviewed every month by senior care workers.

People told us they enjoyed activities at the service. A person told us, "I like being able to go out for walks." Another said, "Most days, we have activities, like nail painting, bingo or dominoes." People we spoke with knew about activities that were planned and scheduled because they had been given a monthly diary of activities. A person showed us a diary they had been given and told us about activities they were looking forward to enjoying. People told us about outings they had enjoyed to places of natural beauty, theatres and other places of interest. The provider had arranged talks about things that were of interest to people, for example a talk about first world war commemorations. Activities provided a mix of recreation and stimulating activity. People made things during arts and crafts sessions, people played games that encouraged physical exercise and movement, and others played dominoes or other table games. People were supported with spiritual needs through visits by representatives of local places of worship. People were also able to follow their personal interests. For example, who liked knitting was provided with what they needed. People had magazines and newspapers of their choice. People who liked reading had a range of large print books they chose from. People who liked particular television or radio programmes were reminded when those programmes were broadcast so they could watch them.

Staff were responsive to people's needs. Staff were present in the communal lounge and were alert to people's needs. Staff made discrete observations at regular intervals of people who spent most of their time in their rooms. People told us that when they had used call alarms to summon assistance staff had responded quickly.

A person who used the service told us, "I like to be independent but I also like to go to other rooms to mix with people. It's a happy atmosphere here." The provider encouraged relatives to stay for meals with people who used the service. People were encouraged to maintain contact with relatives and family they wanted to see so they were not socially isolated. People had made friendships with other people who used the service. We saw people mixing and socialising.

People we spoke with expressed full confidence in being able to raise any concerns they had about their care and support. A person who used the service told us, "I can talk to any of the staff; I've spoken with the owner." They added that they went to residents meetings. A relative told us, "There has been no occasion when I've had to raise a concern." This meant that people had confidence to raise concerns and felt they would be listened to.

People who used the service had access to a complaints procedure. We were told no complaints had been received since our last inspection. The service had arrangements for investigating concerns. We saw that a concern that had been raised anonymously by a person who worked at the service had been thoroughly investigated.

Is the service well-led?

Our findings

At the time of our inspection the registered manager was absent from the service. The service was being managed by an interim team consisting of the provider and two senior care workers who had been appointed to assistant manager positions. The interim management arrangements could last until February 2015 when it was expected that the registered manager would return. People who used the service and staff knew about the interim management arrangements. This showed that the provider was open about the management arrangements for the service.

People we spoke with reported no negative impact on them because of those arrangements. The interim management team were self-critical but they understood the challenges the service faced in forthcoming months and had identified improvements they wanted to make. The interim management team were working with a quality improvement team from the local authority to implement improvements.

The provider had arrangements for the assessing and monitoring the quality of service. Those arrangements included a series of checks carried out by the assistant managers. Checks were made of care records such as food and fluid intake charts, turn charts and records of care routines. The monitoring records showed that the checks had been carried out, but did not show what the outcomes and findings of the checks were. Areas of good practice or areas requiring improvement had not been identified through the monitoring activity. For example, checks of records associated with controlled drugs stored at the service had not identified inaccuracies in those records. This meant that the monitoring activities did not provide an informative assessment of how well the service was doing. This was an area the provider was addressing with the help of the local authority.

The provider was in the process of gathering regular feedback from people who used the service. This was through a `resident listening form'. The form included questions about important aspects of a person's care and support. We discussed with the interim management team how the resident listening form could be improved to encourage people to say more about what they thought of their experience of the care and support they received.

People we spoke with told us they had attended `residents meetings'. At those meetings people had opportunities to be involved in general decisions about how the service supported people. Those meetings usually took place every three months. The meetings were well attended. In March 2014, 15 people who used the service attended. In July 2014, 16 people and two relatives attended. We saw from records of those meetings that people had contributed to decisions about activities and outings and how to use financial donations the service had received.

The provider had procedures for staff to question practice and raise concerns without fear of repercussion. Staff could do so through the provider's whistle-blowing policy and directly with senior staff. Staff told us they had raised concerns. Staff had mixed feelings about whether their concerns had been taken seriously, but we saw that senior staff had acted on those concerns.

Five care workers we spoke with told us they felt excluded from contributing to the development of the service. They told us that only senior staff had meetings. They told us they had declined to participate in a staff survey because they felt their views could not be given anonymously. We discussed this with the interim management team who identified ways the staff survey could be inclusive and how to raise staff involvement in the service.