A1 Residential Care Limited

The Bellingham Residential Care Home

Inspection report

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Lytham
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Ratings

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

Overall summary

This inspection took place on 07 October 2015 and was unannounced. It was carried out by the lead social care inspector for the service, and a Specialist Professional Advisor with a background in the care and support of older people.

The Bellingham is a two storey corner property set in a residential area close to Lytham town centre. The home has thirteen single rooms and one double room. At the time of our inspection visit there were 12 people living at the home. There are en suite facilities in all rooms. There are a range of aids and adaptations available suitable to meet the needs of people using the service. There is a garden area around the home. Public transport links are close by. The was a pleasant atmosphere in the home, and the people living there told us that they enjoyed living there.

The service has a registered manager, however, they were on holiday at the time of our visit. A registered manager is

Summary of findings

a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

A senior carer supported us during our inspection visit. We saw that records of incidents and accidents were kept. The senior carer told us that these were monitored and reviewed in order to identify areas of concern and improvement. We found documentary evidence to show that risk assessments and safety plans were in place relating to different aspects of the home. For example: care planning, treatment, infection control, medication, healthcare and environmental safety. Personal Emergency Evacuation Plans (PEEPs) in the event of a fire, had not been drawn up for each individual living in the home. Staff were aware that they had to notify CQC of deaths at the home, but were unsure of the other types of incidents that were notifiable.

We found written evidence to show that the registered manager had a system in place used to assess and monitor the quality of the service. The senior carer explained that they were involved in auditing different aspects of the service provided. We saw evidence of these audits, and saw that the system had flagged up areas of concern, and minor issues relating to care delivery and service provision. These issues had been actioned, and dealt with appropriately.

The senior carer explained that the staffing numbers and arrangements were reviewed routinely, sometimes on a daily basis, in response to the needs of people who lived at the home. The systems relating to the safe recruitment of staff were found to be appropriate. Safe and effective procedures were followed for all staff, including temporary and agency staff. Information held with the personnel records showed that the service had assessed the character of applicants during an interview process, and had undertaken appropriate safety and employment checks to ensure people were either clear to work in care, or unsuitable for employment. The processes for the safe and secure handling of medicines were found to be appropriate.

We found documentary evidence to show that ongoing assessment, planning and monitoring of nutritional and hydration needs and intake took place. We observed staff offered support to enable people to eat and drink when necessary. This was found to be documented within the individualised care plans.

The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken. We found that action had been taken by the service to assess people's capacity to make decisions. We found written records to show that considerations had been made to assess and plan for people's needs in relation to mental capacity. We found documentary evidence to show that the systems operated within the home relating to consent to care and treatment took into account both local and national official guidance.

Feedback from people about the attitude and nature of staff was positive. Comments included, "They are great staff", "They are lovely and you can have a chat with them". Staff showed they cared for people by attending to their feelings. For example, one person was distressed and a care worker responded to the person. They talked with the person and asked how they were. They gave time for the person to talk and engaged with them.

We looked at the ways in which people were supported to understand the choices they had that are related to their care and support, so that they can make their own decisions. We spoke to four people at the home who said they were comfortable when expressing decisions about their care. Relatives told us that they could approach the staff or manager to discuss issues such as the food, clothing and medication.

Information held within the care plans showed that people had been involved in their assessment of need, depending on their capabilities. This process helped to identify their individual needs and choices, and was based on information supplied by social workers or healthcare staff.

We identified a number of breaches of the the Health and Social Care Act 2008 (Regulated Activities) Regulations

Summary of findings

2014 in relation to staff deployment and training, good governance and safety. You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires improvement

The service was not always safe.

Although risks were identified and control measures were put in place, some were ineffective. Where hazards had been identified, appropriate referrals to healthcare professionals had not taken place.

Fire evacuation plans were not in place for everyone living at the home.

People were protected from abuse by systems in place: staff understood how to respond to allegations or suspicions of abuse.

The provider had robust recruitment procedures in place, with a sufficient number of staff and skill mix. However staffing levels had placed one person at risk of falls.

People medicines were managed by staff who had the competency and skills to administer medication safely.

Is the service effective?

Requires improvement

The service was not effective.

Staff were not always trained and effectively supported.

People were given choices about food and received a balanced diet. Drinks were available, and support was given when required.

Staff understood how to support people who did not have the capacity to make decisions for themselves.

Is the service caring?

Good

The service was caring.

Caring relationships were developed; people were treated with kindness and respect.

Staff interacted well with people living at the home, and people were observed to engage with others in positive ways.

People were able to express their views by being involved in discussions, with staff and family members.

Staff had a good understanding of needs of people in relation to their end of life care.

Is the service responsive?

Good

The service was responsive.

People had access to activities that reflected their interests.

Summary of findings

People knew how to make a complaint and told us they would be comfortable to do so. People knew how to raise concerns and they were good systems in place to deal with concerns in a timely manner.

Is the service well-led?

The service was not well-led

There were quality assurance systems in place which monitored people's well-being and safety, however, in some instances, these were ineffective, and therefore, people were put at risk.

There was an open and friendly atmosphere which enabled people to raise issues and make suggestions.

Staff were unsure of when they were required to notify CQC of incidents that affected people living in the home.

Requires improvement

The Bellingham Residential Care 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.

This inspection took place on 07 October 2015 and was unannounced. It was carried out by the lead social care inspector for the service, and a Specialist Professional Advisor with a background in the care and support of older people.

We reviewed the records we held regarding the operation of the service prior to our visit. We found that the service provider had notified CQC of events such as deaths of people at the home. We also reviewed the information we held about safeguarding incidents in the home, and found that there were no on-going safeguarding incidents.

During this inspection we spoke with six people who lived at the home, three visitors and three members of staff. Throughout the day we observed care practices in communal areas and saw lunch being served in the dining room. We looked d at a number of records relating to individual care and the running of the home. These included five care plans, medication records, three staff personnel files and quality assurance files.

Requires improvement

Is the service safe?

Our findings

We spoke with six people who lived at the home. All of them said they were happy living at the home, and said that they felt safe. One person said, " This is a very 'homely' home. I am very happy living here. The staff are very caring and they keep me safe." Some of the people living at the home had difficulty expressing themselves when we asked them about safety concerns, so we spent some time observing people's engagement and interaction. People looked content and happy, and were seen to move around the home freely, interacting with others.

We found written records to show what the arrangements were to provide safe and effective care in the event of a failure in major utilities, or other types of emergency. Equipment had regular safety checks and there was a quality monitoring system in place. Records held within the home showed that the fire alarm system had been tested and that staff had taken part in regular fire drills. However, we noted that some equipment in the kitchen and cellar area of the home had not been electrically tested, known as PAT tested. (Portable appliance testing (PAT) is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.)

Under current fire safety legislation it is the responsibility of the registered manager to provide a fire safety risk assessment that includes an emergency evacuation plan for all people likely to be on the premises in the event of a fire. In order to comply with this legislation, a Personal Emergency Evacuation Plan (PEEP) needs to be drawn up for each individual living at the home. Information held within the care records showed that PEEP's had not been completed. The senior carer explained that she was unaware of the need for PEEP's to be in place.

Accidents and incidents were documented, and we saw that if action was needed to be taken to address issues or change practice, this was completed by the staff. We looked at the care files of five people and found that risk assessments and care plans had been updated following incidents such as falls or illness. However, we noted that in one instance, a person who experienced diabetes did not have an up to date risk assessment that would be used to give guidance to the staff team on how to deal with this person's on-going health condition.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service provider must prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. The service provider must assess the risks to people's health and safety during their care or treatment, and take action to minimise or eliminate those risks.

Staffing levels were checked and were found to be operating at a minimum level. We found that there were three care staff on duty who were supporting 12 people. In the afternoon, we observed staff to be engaged in various caring duties around the house whilst a group of singers entertained people in the lounge. During this time, one person who used a walking frame was seen to regularly get up out their chair and walk around the room without their walking frame. At one point, one of the visiting singers guided the person back to their chair because they were worried that this person may fall. This person was later seen walking around the house, and another person was observed to alert staff to their movements. We checked the care file for this person, and found that they had been assessed as being at risk of falls when mobilizing and needed the support of a carer when walking. We explained to the senior carer that this situation posed a potential risk to the health and welfare of the person who was moving around the home, and they then ensured that a staff member was located in the lounge to ensure that person was properly supervised.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service provider must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs.

Information held within the records showed that care workers had received training in safeguarding adults during their induction. Staff knew the different types of abuse that could take place, and were aware of the procedures in place that they should follow if they had safeguarding concerns. The processes in place within the home for identifying and responding to signs and allegations of abuse were found to be appropriate. Safeguarding information was visible in the registered manager's office that gave details of how to recognise potential abuse, and how to respond to it appropriately.

Requires improvement

Is the service safe?

The systems relating to the safe recruitment of staff were found to be appropriate. Safe and effective procedures were followed for all staff Information held within the personnel records showed that the service had assessed the character of applicants during an interview process, and had undertaken appropriate safety and employment checks to ensure people were either clear to work in care, or unsuitable for employment. The senior carer explained that the application and interview process was in place to check that potential staff had the right skills and qualifications needed to do the job. After people were employed, the service provider had a robust procedure in place if they needed to take disciplinary action against a staff member for whatever reason. This included referrals onto other relevant agencies, be that their professional body or the Disclosure and Barring Service. We found that all disciplinary action taken against staff was well documented.

The processes for the safe and secure handling of medicines were found to be appropriate. The service was found to have a clear process in place for the handling of controlled drugs when necessary. The process in place to ensure a person's prescription was up to date and reviewed was found to be appropriate, and took into account their needs or changes to their condition or situation. Information held within the records showed that staff received training in the safe administration of medicines. However, when we asked the staff about the different uses for medicines held at the home, and their side effects, the staff responses showed a limited understanding. We explained to the staff that having an understanding of side effects of medicines is vital when understanding people's on-going care needs, and how to respond to them when required to do so.

We recommend that the service provider consult the relevant guidance on the safe handling and administration of medicines such as 'Handling medicines in social care settings' produced by Royal Pharmaceutical Society of Great Britain or the NICE guidance on medication.

Requires improvement

Is the service effective?

Our findings

People living at the home had difficulty expressing themselves when we asked them about the effectiveness of the home, so we spent some time observing people's engagement and interaction. People engaged with the staff team, and other residents at the home. The staff were seen to interact with people in positive ways, and this showed that they understood how they needed to respond to people's needs.

Staff explained that service had a training and supervision programme, however, this was found to be very limited, with staff being provided with basic mandatory training when they first started work at the home. Staff with particular roles within the home, such as the administration of medicines, were provided with further training, but staff told us they did not always receive update training as required. One staff member told us that they had not received any update training on any subject in the last 12 months, even though their training records showed that they needed these updates. The records showed that there were gaps in the staff training updates.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service provided must ensure that staff receive the support, training, professional development, supervision and appraisals that is necessary for them to carry out their role and responsibilities.

We found documentary evidence to show that ongoing assessment, planning and monitoring of nutritional and hydration needs and intake took place. We observed that food and hydration was provided and made available in sufficient quantities and on a regular basis, and this was supported by comments from people living at the home. We found there to be a choice of food and drink that took account of people's individual preferences. People said that they could decide when to eat and where to eat.

We observed staff offer support to enable people to eat and drink when necessary. This was found to be documented within the individualised care plans. We found information to show that some people had been assessed as being at risk of losing weight and of dehydration. Systems were found to be in place to monitor and manage these risks, and record keeping was both accurate and up to date.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken. We found that action had been taken by the service to assess people's capacity to make decisions. We found written records to show that considerations had been made to assess and plan for people's needs in relation to mental capacity.

We found that the service had appropriate processes in place to ensure that people were able to give consent to their support and care. Where people lacked capacity, the staff and manager knew how to comply with the MCA. Assessment and review processes were found to be in place to ensure that staff and relatives were kept up to date with a person's situation, and to ensure that staff followed the correct procedures when supporting people who lacked capacity. We found documentary evidence to show that the systems operated within the home relating to consent to care and treatment took into account both local and national official guidance. Where needed, mental capacity assessments took place; best interest meetings were convened and referrals to the Local Authority were made if a DoLS was required. The staff we spoke with understood the need to ensure people were enabled to give consent to care, and understood the requirement to seek external advice and guidance if there were any doubts about a person's ability to make informed decisions. The training records showed that staff had either received training in this area, or were due to undertake such training.

Good

Is the service caring?

Our findings

Feedback from people about the attitude and nature of staff was positive. Comments included, “They are great staff”, “They are lovely and you can have a chat with them”. Staff were seen to be caring and compassionate. For example, one person was distressed and a care worker responded to the person. They talked with the person and asked how they were. They gave time for the person to talk and engaged with them. People’s bedrooms were personalised and contained photographs, pictures, ornaments and other items each person wanted in their bedroom. This showed that people had been involved in establishing their own personal space within the home.

We looked at the ways in which people were supported to understand the choices they had that were related to their care and support, so that they could make their own decisions. We spoke to four people at the home who said they were comfortable when expressing decisions about their care. One person said that they could approach the staff or manager to discuss issues such as their food, clothing and medication. A number of people were unable to express a view about their involvement in decision making, so we spoke to a visitor who was visiting their relative. They told us that they felt they could influence the care and support their relative received, and explained that they had been involved in significant decisions about their relative’s healthcare. We found documentary evidence to support this in the care plans and risk assessments.

We observed care workers knocked on people’s doors before entering rooms and staff took time to talk with people or provide activities. People were treated with dignity and respect by staff and they were supported in a caring way. Staff talked with people and involved them in activities. Care workers used people’s preferred names and we saw warmth and affection being shown to people. People recognised care workers and responded to them with smiles which showed they felt comfortable with them. Tasks or activities were seen not to be rushed and the staff were seen to work at people’s own pace.

Staff confirmed that if someone needed to be cared for at the end of their life, then every effort would be made to ensure this could be done. They explained this would involve careful planning with the person and their family, and may involve input and support from external agencies, such as GPs and district nurses. Although not specifically trained in end of life care, staff gave a good account of how they would support people at times like this.

People were involved in decisions about their end of life care. For example one person had a ‘do not attempt cardio pulmonary resuscitation’ (DNACPR) order document in place and an advanced care plan (a plan of their wishes at the end of life). We saw the person and their family were involved in this decision.

Good

Is the service responsive?

Our findings

People spoke positively about the responsiveness of staff and the provider. People and their relatives told us they felt involved in how their care was provided. One person said, "If I want to do something such as go for a walk, or get something from the shops, then the staff always do their best to accommodate me." People told us they would know who to raise any concerns with if they had a complaint and a relative told us "I think the manager is excellent here, they are very responsive if I have concerns." Another relative told us, "If something goes wrong, they listen."

Information held within the care plans showed that people had been involved in their assessment of need, depending on their capabilities. Generally, this process helped to identify their individual needs and choices, and was based on information supplied by social workers or healthcare staff. If the person was unable to contribute, information had been actively sought from others such as family members and friends. Written personalised care plans, which detailed people's individual needs and choices, had been put together by the staff and the person in receipt of care where possible. The reviews showed that where possible, the person themselves had been involved, and if this wasn't possible, family members and others important had been consulted.

The staff we spoke with understood the importance of involving people in appropriate activities which helped people feel involved and valued. Staff told us activities were based on people's preferences. For example there were one to one activities such as talking about the news, reminiscence, arts and crafts. The daily notes in the care plan recorded what activities and events the person was involved in.

The home has a suitable complaints policy and procedure that is publicised in its Statement of Purpose and the documentation was provided to new people entering the home. A record of complaints was kept and examined. The senior carer explained that they had been involved in a long running complaint regarding a former resident. We reviewed the records relating to this complaint, and found that the organisation had liaised openly and honestly with the complainant, and provided them with up to date and accurate information relating to their complaint.

The home had appropriate processes in place to ensure that when people were admitted, transferred or discharged, relevant and appropriate information about their care and treatment was shared between providers and services. Information held with people's personal care records showed that liaison had taken place with other health professionals and a relative spoken with confirmed that they had been involved with the assessment process and had been kept informed at every stage. Staff at the home sated that confidential information was only shared about a person once it was established it was safe to do so. We observed this in practice when a staff member spoke to a relative over the telephone regarding a sensitive healthcare matter.

Requires improvement

Is the service well-led?

Our findings

Staff confirmed that they received regular handovers (daily meetings to discuss current issues within the home). They said that handovers gave them current information to continue to meet people's needs, and updates regarding incidents, and what action to take to minimise or reduce the possibility of further accidents or incidents.

We saw that records of incidents and accidents were kept. The senior carer told us that these were monitored and reviewed in order to identify areas of concern and improvement. We found documentary evidence to show that risk assessments and safety plans were in place relating to different aspects of the home. For example: care planning, treatment, infection control, medication, healthcare, environmental safety and staff training. We found written evidence to show that the service had a system in place to assess and monitor the quality of the service. Staff explained that they were involved in auditing different aspects of the service provided. We saw evidence of these audits, and saw that the system had flagged up areas of concern, and minor issues relating to care delivery and service provision. These issues had been actioned, and dealt with appropriately. However, as previously mentioned, the quality assurance system operated at the home had not identified the need to ensure fire plans were in place, and the referrals to external agencies where required. Also the systems in place had not effectively identified gaps in staff training and supervision.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance

On checking the records of 2 people who lived at the home, we noted that they had been to the local hospital for treatment following a fall. We reminded the senior carer of the requirement of notify CQC of these types of incidents. The senior carer explained that they were aware that they had to notify CQC of deaths at the home, but was unsure of the other types of incidents that were notifiable.

The failure of the service to notify CQC of instances when people had required hospital treatment was a breach of Regulation of the Care Quality Commission (Registration) Regulations 2009.

The people we spoke with (service users, staff and a relative) all said that the registered manager and management team provided good leadership. The home was well organised and we found that there were clear lines of responsibility. There were systems in place to monitor if tasks or care work did not take place. One staff member said, "We have a communication book, and a records system, and using these lets us pass on information to other staff members, and we can make sure that people's needs are met." We observed the senior carer talk to people throughout the day and they spent time ensuring people were content and happy with the service they were receiving..

Service user surveys were sent out and their responses noted. We were shown the results from the last survey in 2013/2014, and the result were positive. At the time of our visit, this year's annual survey had not been sent out, and the staff were unsure when this would take place. We saw evidence of evidence of service user meetings which were dated 2013. The staff said that service user meetings did take place, but were not always recorded. People at the home said that they did sit down with the staff and other people at the home from time to time to discuss how things were progressing, but said that this was infrequent. One person said, " We don't always need a big meeting because we see each other every day, and if there is a problem or issue to discuss then we do it there and then."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not provide care and treatment in a safe way for service users, and did not take account of relevant legislation and recognised guidance about delivering safe care and treatment. Regulation 12(1) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered manager did not have an effective system in place to ensure the quality and safety of the service was properly assessed and monitor, in order to mitigate against the risks relating to the provision of the regulated activity. Regulation 17(1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service provider must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs. Regulation 18(1).The service provided must ensure that staff receive the support, training, professional development, supervision and appraisals that is necessary for them to carry out their role and responsibilities. Regulation 18(2) (a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

This section is primarily information for the provider

Action we have told the provider to take

The service provider must ensure they notify CQC of all incidents that affect people in the home, as required by regulation.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.