Ideal Carehomes (Leeds) Limited

Berkeley Court

Inspection report

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Ratings

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

Overall summary

We inspected Berkeley Court on 3 November and 7 November 2014. The visit was unannounced. Our last inspection took place on April 2014 and, at that time, we found the service was not meeting the regulations relating to management of medicines and staffing. We asked them to make improvements. The provider sent us an action plan telling us what they were going to do to ensure they were meeting the regulations. On this visit we checked and found improvements had not been made in all of those areas.

Berkeley Court is in a residential area off Harehills Lane in Leeds. It is close to the city centre and St James' Hospital and has excellent transport links to the neighbouring areas of Crossgates, Seacroft and Halton.

The accommodation for people is arranged over three floors. There are two units per floor. Each unit has single bedrooms which have en-suite facilities. There are communal bathrooms and toilets throughout the home. There are open plan communal lounges and dining rooms on each of the units.

Summary of findings

There was a manager in post; however this person was not registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. On the day of our inspection the new manager of the home had recently commenced their employment.

On both days of our visit's we saw people looked well cared for. We saw staff speaking in a caring and respectful manner to people who lived in the home. Staff demonstrated that they knew people's individual characters, likes and dislikes.

People's safety was being compromised in a number of areas. This included the staffing levels in place at night. We found that when staff were administering people's medicines at night there were a number of people at the home who were not supervised by staff. This meant people were not safe.

We were unable to find evidence within care records to show people had been involved in the planning of their care. People we spoke with told us they were not aware of their care plans and could not recall having input in their reviews.

Staff were not always following the Mental Capacity Act 2005 for people who lacked capacity to make a decision. We also saw that where mental capacity assessments had been carried out these were not decision specific. We also saw evidence in people's care records which showed the home were not obtaining consent from people.

We found the service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

We saw evidence which showed some staff at the home had not received supervision. Staff we spoke with told us they did not feel supported by the management team at the home. One staff member said "You only ever get spoken to if you've done something wrong." We looked at staff training records which showed staff had received adequate training to perform their roles. We also saw training was booked to ensure staff skills were kept up to date. This meant people received support from staff who had the required skills and training to meet their needs.

People enjoyed the food and we observed people were offered choice and independence in accessing food and drink was promoted. People's nutrition and hydration needs were being met. People said they received appropriate healthcare support when required. For example people said, "The GP visits whenever they are needed."

We observed positive interactions between people who used the service and staff. For example, we observed one staff member being very patient showing a person how to do things whilst at the same time talking them through the activity.

People we spoke with said they felt comfortable to raise concerns with staff who assisted them. For example one person told us "I am really happy here." "The staff are really good." Staff we spoke with told us they would immediately raise any concerns with their manager and they were confident they would take action to address concerns raised.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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?

The service was not safe. We saw inadequate staffing levels in the home at night which meant there were areas of the home which were left unsupervised by staff for periods of time. This meant people were at risk.

We found that appropriate arrangements were not in place to give medicines safely.

Staff understood the safeguarding procedures and knew how to put them into practice.

Inadequate

Is the service effective?

The service was not always effective. Most people told us they were happy with the care provided at the home and that they thought their care, treatment and support needs were being met.

Staff were not always following the Mental Capacity Act 2005 for people who lacked capacity to make a decision. We also saw that where mental capacity assessments had been carried out these were not decision specific.

We looked at records which showed staff at the home received training which ensured they had the necessary skills to perform their roles. We saw some staff who worked at the home had never received supervision.

Requires Improvement

Is the service caring?

The service was caring. Staff who worked at the home were kind and caring. They told us they felt they provided people with a good quality of life.

We observed positive interactions between people who used the service and staff. We noted staff talking to people and trying to get them to engage them in everyday activities.

People said their privacy and dignity was respected. We observed staff speaking to people in a kind and caring way and knocking on doors and asking permission before entering rooms.

Good

Is the service responsive?

The service was not always responsive. Action was taken to reduce individual risks to people living at the home.

Some activities were on offer, but there were times when people were unsupervised and unoccupied.

We saw in three people's care records the documents in place for end of life care had not been completed.

Requires Improvement

Summary of findings

Is the service well-led?

The service was not well led. The provider had a quality assurance system in place however; we found that where issues were identified, actions were not always taken. This meant issues were not resolved.

We found audits of care records highlighted common themes of issues in care planning however, no actions were recorded. Where audits of equipment had been completed we found evidence which showed no action had been taken in response to faulty equipment. This meant the audits were not effective.

The manager in post at the time of the inspection was not registered with the Care Quality Commission.

Requires Improvement

Berkeley Court

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, and to provide a rating for the service under the Care Act 2014.

We inspected Berkeley Court on 3 November and 7 November 2014. The visit was unannounced. The inspection team consisted of two adult social care inspectors and a pharmacist inspector.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with 12 people who were living in the home, three visitors who were relatives of people, eight support staff, the home manager and the area manager. Following the inspection we spoke with the local authority about the service.

We looked at eight people's care records and four staff files as well as records relating to the management of the service. We looked round the building and saw people's bedrooms (with their permission), bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

Our last inspection took place on April 2014 and, at that time, we found the service was not meeting the regulations relating to management of medicines and staffing. We asked them to make improvements. The provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations. On this visit we checked and found improvements had not been made.

We found the service was not safe. At our last inspection in April 2014 senior managers of the service had identified the medicines policy needed to be updated because they had identified additional information was required to ensure medicines were given safely. The provider told us in their action plan the medicines policy would be updated. We found the policy had not been updated and no account had been taken of the latest NICE guidance published in March 2014.

We looked at records about medication and medication administration records (MAR) for 14 people who were living at the home. We found there were concerns about medicines or the records relating to medicines for all 14 people. People did not have a continuous supply of their medicines. We saw three people were prescribed Paracetamol regularly, but each person ran out of their Paracetamol for two days. We were told that no other Paracetamol was purchased or available for them to ensure they had pain relief. This meant people may have experienced unnecessary pain during that time.

We saw that medicines which needed to be given half to an hour before food were given with medicines which should be given with or after meals. This meant medicines were not given at the correct time to ensure they worked properly and as prescribed.

We saw that one person who went out twice a week at lunch time were unable to have their prescribed medication. This was because staff had not made any arrangements for them to be given. This may have placed the person's health at risk of harm.

We saw where people were prescribed regular Paracetamol there were no records made about the time each dose was administered.

We saw the morning medicines round was not completed until 10:30 am. This meant people could be given their lunchtime doses of Paracetamol with an unsafe time interval between doses.

We found the quality of the information available as guidance for staff on how to give medicines which were prescribed to be given on an 'as required' basis was not adequate. We found the information was not robust enough to ensure people were given their medicines safely and consistently at all times. We found there was no information available to guide staff on the dose to give when a variable dose was prescribed. The lack of information may result in people not being given their medicines safely.

We looked at the records of applications of creams and found there were gaps and missing signatures. We also noted when staff applied creams; they often made their entries to record this some time after they had applied creams and not at the time of application. This meant it was not possible to tell if creams had been applied properly. We looked at records about other medicines and found there were very few gaps however, we found when gaps were identified, staff were asked to go back and sign the charts. It is not safe to retrospectively sign the charts as staff cannot be expected to remember each medicine they have given after a period of time. This showed accurate records were not maintained which meant people were not safe from harm.

This breached Regulation 13 (Management of medicines) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

We saw the home had carried out recruitment for support staff since our last inspection in April 2014. This meant the service reduced the number of agency hours they were using. However, we remained concerned about staffing levels in place at the home. We looked at the staffing levels in place for care at night. There were six staff in the building between 10pm and 7am. We were told by staff and the operational manager that one staff member was based on each of the six units throughout the night. We found that during this period staff had to leave their unit unsupervised to carry out medication rounds or assist with helping people who required two staff to support them. This meant people on some units were left unattended by staff for indefinite periods of time and were not safe. Most people

Inadequate

Is the service safe?

we spoke with told us they thought there were enough staff at the home, for example one person said, “They normally come straight away if I call them.” However, some people thought the home could do with more staff at times. We spoke with two people living at the home and they told us they felt there were not enough staff at night. “We have to wait ages if we want any help. I’ve tried to go out of my room and find staff but sometimes you just can’t find anyone.” Another person told us “I usually check on a friend who lives here too, just to make sure they are ok. We know staff are busy but we still need help.” We also spoke with one person’s relative who told us “You can spend a long time looking for a member of staff at times they never seem to be about.” Another relative we spoke with told us they had concerns about the staffing levels being inconsistent and not always adequate. They gave example of how this had impacted on their relative; “When I come to visit I’m told by my mum staff takes ages to take her to the toilet.” We spoke with the operational manager about the concerns people had raised with us. They told us they felt the home was adequately staffed and increases in staffing were not necessary.

We were told by staff that when they took their breaks at night their units were not covered by another staff member. They told us this worried them as they knew the dependency levels of people living at the home were high.

Three of the seven staff we spoke with told us they thought the home did not have enough staff. Records of accidents and incidents for one person showed they had a number of unwitnessed falls throughout the night. Another person whose behaviour had become increasingly challenging and inappropriate was required to be checked every 30 minutes when they were awake. We saw one incident had occurred recently at 3am. Staff we spoke with told us this person did not always sleep throughout the night and often wandered around the unit. This meant people were not safe.

This breached Regulation 22 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Staff we spoke with had a good understanding and knowledge of safeguarding. Staff told us they knew people well and would be able to recognise signs which may indicate possible abuse or neglect. Staff told us they understood the procedure to follow to pass on any concerns to senior staff or the manager of the home and felt these would be dealt with appropriately. Staff were clear about their responsibility to report concerns and were aware of whistleblowing procedures and how to use them. Staff told us they had received safeguarding training for adults and children, which the training matrix confirmed.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective. Most people told us they were happy with the care provided at the home and that they thought their care, treatment and support needs were being met. From our observations and from speaking with staff and people who lived at the home and their relatives we found staff knew people well and were aware of their support needs.

People we spoke with told us they received appropriate healthcare support. For example people said, "The GP visits whenever they are needed." Care plans showed people were routinely referred to community health professionals such as community nurses and doctors. The outcome of these visits was documented to assist care staff in meeting peoples' needs. This showed people received additional support when required for meeting their care and treatment needs.

We observed people being supported by staff to eat their meals in a dignified and respectful manner. People who were at identified as being at risk of losing weight were prompted throughout the day by staff with snacks to boost their calorific intake. Monitoring of people's nutritional intake was also taking place and records we looked at were up to date.

We looked at the care records of eight people who lived at the home and we saw the home was carrying out assessments of people's mental capacity to see if they were able to give their consent. However, in three of the records we found there were no documents in place to show people had consented to their care and treatment at the home. In one person's records it was identified the person was able to make every day non-complex decisions. However, we saw the person had not given their consent to any aspect of the care they received at the home. For example, we saw the home used a 'restrictive practice document' as some areas of the home had doors which were key pad protected. We saw this person had an assessment carried out in relation to this however; the outcome had not been completed and we also saw the person had not been involved. We saw in another person's care record the person was unable to consent or make decisions. The person's relative had given consent on their behalf however; we found the home had not carried out 'best interest decisions' in relation to the support the person was receiving at the home. This showed the home was not meeting the requirements of the Mental Capacity Act 2005. We have asked the provider to make improvements.

This breached Regulation 18 (Consent to care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

We looked at records which showed staff at the home received training which ensured they had the necessary skills to perform their roles. We saw the staff at the home had attended annual training with six monthly updates in all training considered to be mandatory by the provider for example, safeguarding adults, dementia awareness, food hygiene, emergency first aid, fire, health and safety/COSHH and infection control. Staff we spoke with told us they attended lots of training and had been encouraged to undertake further training such as NVQ levels two and three. We also saw staff who were new to the service training was booked for them to attend.

We spoke with the operational manager who told us staff should receive supervision every two months. We looked at the records of staff supervision and saw 25 staff out of 67 staff were overdue in having supervision. The records showed the number of days each staff member was overdue. We saw the highest number of days overdue were 852, 664, 852, 1044, 447, 124, 214, 738 and 579 days. The records we looked at showed some staff members had never received supervision during their period of employment at the home. We spoke with staff who told us they very rarely received supervision and when they did they did not see it as supportive. One staff member told us "When you do something wrong they get you in straight away but we never get told about the things we do well." Another staff member said "I don't have supervision, I never have. I suppose I'll just have to wait until I do something wrong." One staff member said they had worked at the home for years and had never felt supported by the provider. They told us "We're just a number. We get shouted at when things go wrong but you never hear anything from them when you're doing things well." We discussed this with the area manager who told us they were aware of the lack of supervision taking place at the home. They told us the previous manager of the home had been managed by them and although they did not have to submit any

Requires Improvement

Is the service effective?

evidence to show the supervision taking place on a monthly basis, they had been aware of the concerns. They told us they had taken action in response to this however; we were not shown any evidence of this. This showed that staff were not receiving regular management supervision to monitor their performance and development needs.

This breached Regulation 23 (Supporting workers) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Good

Is the service caring?

Our findings

Staff told us they felt they provided people who lived at the home with good care and they had a good staff team. People living at the home seemed genuinely pleased to see staff members when they came both into individual rooms and when seen in communal areas. When we looked around the home we saw people's bedrooms had been personalised and contained items such as family photographs and ornaments. We saw people looked well dressed and cared for. For example, people were wearing jewellery and had their hair combed. This indicated that staff had taken the time to support people with their personal care in a way which would promote their dignity.

People we spoke to said they were happy with the care they received, they said that staff were very nice. One person said "The staff are nice" Another person said "Yes I am happy with the care I get. They are all very good to me". People said staff respected their choices, for example one person said, "I prefer to stay in my room and staff respect this choice. When I want to join in group things they assist me to do so." This showed that people living at the home were encouraged to maintain their independence and make their own choices about their life at the home.

People said their privacy and dignity was respected. We observed staff speaking to people in a kind and caring way and knocking on doors and asking permission before entering rooms. People said when staff were providing personal care, doors were closed and curtains drawn. We noted that this was routine during our observations on the day of the inspection. This showed that people's privacy and dignity was maintained at the home.

We spoke with five staff about people's preferences and needs. Staff were able to tell us about the people they were caring for, any recent incidents involving them and what they liked and disliked. This showed care staff knew what was important to the people they cared for and helped them take account of this information when delivering their care. However, in two of the care records we looked at we saw documents regarding people's choices, preferences and life histories had not been completed. We found staff who had worked at the service for some time were aware of individual's preferences but new staff were dependent upon getting this information verbally. If completed, the documents would have helped all care staff to know what was important to the people they cared for and help them take account of this information when delivering people's care.

We spoke to the chef who told us people could choose what they wanted to eat and if someone did not want what was on the menu they were offered an alternative. We observed one person asking for a different meal to what was on the menu and being given what they had asked for.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive. We saw action was taken to reduce individual risks to people who lived at the home. For example, we looked at the monitoring in place of the number of unwitnessed falls at the home in August, September and October 2014. We saw examples of where the home had involved other agencies such as the falls team to obtain equipment which would alert staff if the person needed assistance. However, we did not find evidence which showed the home was using the information in a way which prevented further falls.

Some activities were on offer, but there were times when people were unsupervised and unoccupied. For example, we saw some people preferred to spend time in their rooms. We spoke with three people who told us they did not often see staff because they did not like to join in the group type of activities. One person told us "I don't really need them to give me much help. I like to sit in my room but it would be nice if they had time to sit and have a chat." Another person told us "I would like to go out but I know there isn't enough staff to take me." We were also told "If you can do for yourself you are left to get on with it. I know they're good staff but they are too busy to come and see us in our rooms."

We looked at the care records of eight people who lived at the home and we were unable to find evidence to show people had been involved in the planning of their care. For example, we saw people had not signed their care plans. We also saw that where care plan evaluations and reviews had been carried out; documents were not signed to show the involvement of the person concerned. We looked at assessments of needs which had been carried out following a person's admission to the home. These documents had been left blank where the person concerned was required to sign. This showed that people had not been involved.

People we spoke with told us they were involved in making decisions about their care. However they also told us they were not aware of their care plans and cannot recall having an input in their reviews. This meant that people had not been involved in their care planning or the reviews of their care.

This breached Regulation 17 (Respecting and involving service users) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

We saw in three people's care records the documents in place for end of life care had not been completed. Having an end of life plan in place increases the likelihood that the person's wishes are known and respected at the end of their life.

People we spoke with knew how to make a complaint and who to go to if they had any concerns. We saw people had access to the complaints procedure as this was displayed in the home. The complaints procedure gave details on what a person could expect in terms of timescales for their complaint to be dealt with. We looked at the complaints log and saw the home had received two complaints since our last inspection in April 2014. We saw that both of the complaints had been investigated however, one of the complaints did not show evidence of being resolved. We saw the second complaint had been resolved however, as it related to a staff member the details were not recorded in the file and were held at the provider head office. We did discuss the outcome with the area manager who had carried out the investigation and taken action in response. This showed the complaints people made were responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well led. The provider had a quality assurance system in place however; we found that where issues were identified, actions were not always taken. For example, we looked at medication audits completed as part of the 'Quality assurance monthly evaluation' in place for October and November 2014. Both of the audits showed there were on going concerns with regard to staff failing to record the administration of 'as required' medication. This was recorded as having an impact on the stock levels of medication in the home. However; we found no evidence to show action had been taken in response to this. We also saw a visit to the home had been carried out by the provider in October 2014 specifically for the purpose of looking at processes around the management of medicines in the home. Following this we saw a list of actions was identified for the home manager to carry out. However; we were unable to find evidence to show any of the actions had been carried out. We looked at results of two compliance visits to the home by the provider in August and September 2014. Both visits identified areas of concerns around the management of medicines within the home. For example, staff were not recording administration of topical medicines and medication errors by staff were occurring. We also found areas of the 'Quality assurance monthly evaluation' had not been completed. For example, in October 2014 we found 'Falls' and 'Dependency return' had not been completed. This meant the audit system in place was not effective as it did not ensure issues raised were resolved and secondly the audit tool was not being fully completed.

We found audits of care records highlighted common themes of issues in care planning however, no actions to rectify the issues were recorded. For example, we looked at six care plan audits which had been carried out in October 2014 and eight which had been carried out in November 2014. We saw the audits had not been signed by the person completing them. There was no evidence to show where concerns had been identified that action had been taken, on what date or by whom. We saw actions identified included: people and/or their relatives had not signed documents, no identified keyworker, no weight recorded for one month, resident details and life history not completed, care plan not in place for someone identified as being a high risk of falls, no entries in religious, social or other activities and no resident /representative signatures when care plans were reviewed. We saw the audits had not been signed as required by the manager or the area manager. This meant it was not clear if action had been taken to resolve the issues identified.

We looked at two mattress audits which had been carried out on 1 and 11 October 2014. We saw that both audits identified nine mattresses had failed. We were unable to find evidence which showed action had been taken. We spoke with the area manager who told us no action had been taken. This showed that the audit system in place at the home did not ensure that where issues were identified action was taken.

We looked at how the home gathered the views and opinions of people who lived at the home and their relatives, and used the information to improve the quality of the service. We were shown surveys which had been completed by people and their relatives. We found the comments were positive and complimentary of the staff. We saw the home also held regular resident meetings which were well attended by people at the home. However, we found there was a lack of evidence to show how the home had responded to the issues raised. For example, at the meeting held in October 2014 suggestions for activities were made but we saw that there was no response to this. We also saw there had been some suggestions put forward regarding different foods people would like to see on the menu. We found no evidence to show this had been actioned. This showed that people's views and opinions were not taken into account in the way the service was provided.

The manager of the home was new in post at the time of our inspection. We spoke with three staff about how they found the leadership and management at the home. One staff member told us "It's hard at times as there isn't really anyone you can talk to about concerns you have. If you do something wrong they are straight on it but you never get told when things are done well." Another staff member said "We work as a team. It's the only way to get the work done as we are so busy. Some people need us to do everything for them. You can't always ask other units to help out as they are just as busy too." Staff told us they had staff meetings but did not feel able to discuss their concerns openly. They told us "They just make you feel like you're being negative so I just don't say anything." This suggested the home did not promote an open culture.

Requires Improvement

Is the service well-led?

This breached Regulation 10 (Assessing and monitoring the quality of service provided), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met: The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others. Regulation 10 (1) (a)(e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services How the regulation was not being met: People who used the service were not enabled to make, or participate in making, decisions relating to their care or treatment. Regulation 17 (1) (b) 2(b)(c)(i)(ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: Before people received any care or treatment they were not asked for their consent and where people did not have the capacity to consent, the provider did not act in accordance with legal requirements. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not being met: People were cared for by staff who were not supported to deliver care and treatment safely and to an appropriate standard. Regulation 23 (1) (a).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Regulation 13.

The enforcement action we took:
Warning notice to be met 28 February 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: There were not enough qualified, skilled and experienced staff to meet people's needs. Regulation 22.

The enforcement action we took:
Warning notice to be met 28 February 2015.