Cumbria Care

Bevan House

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place on 18 June 2015. We last inspected Bevan House in August 2013. At that inspection we found the service was meeting all the regulations that we assessed.

Bevan House provides accommodation and personal care for up to 40 older people, some of whom may be living with dementia. On the day of the inspection there were 22 people living in the home and two of the five units were unoccupied and closed. The service was only taking in new respite admissions. This was because Bevan House is one of the registered provider's care homes that is due to close in the future as part of a programme to develop a new build care home locally.

The home is in a residential area of Barrow in Furness and close to bus routes into town. The home is on two floors divided into five living areas or 'units'. On the ground floor is accommodation on two units for people living with dementia. Each of the five units in the home has its own separate lounge and dining areas with a small kitchenette, toilet and bathroom facilities for those living there. There is a small car park to the rear and some outside patio space for people to use. The home has its own kitchen where food is prepared each day. There is a room for the use of people who wish to smoke and also a large communal lounge for people to use and for entertainments.

Summary of findings

The service did not have a registered manager in post at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The registered manager had moved to another post within the organisation. The registered provider has recruited a suitable person who was in post and in the process of registering as the manager with CQC.

We spoke with people living at Bevan House in their own rooms and with those who were sitting in the communal areas. People told us that they were being looked after "very well" and that staff "did their best" to take care of them as they wanted. Relatives we spoke with told us that they did not have any concerns about how their relatives/friends were looked after and supported by the staff in the home.

We discussed the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) with the staff in the home. They had an understanding of the principles involved and what actions needed to be taken for people. We found that the information on file for decisions made around resuscitation and powers of attorney was not consistent. There were no clear records of who the people or representatives involved were or of the discussion or best interests meeting having taken place where there was a possible lack of capacity. We found a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because formal policies and procedures were not in place in line with the MCA and associated code of practice. Staff had not consistently assessed people's capacity and their ability to be involved in decision making and give consent in line with legislation.

You can see what action we told the provider to take at the back of the full version of the report.

We spent time with people on the three units. We saw that the staff offered people assistance but respected their independence. We saw that staff took the time to speak with people and took up opportunities to interact with them, engage and offer reassurance if needed.

The care plans and records that we looked at showed that people were being seen by appropriate professionals to help meet their particular physical, nursing and mental health needs. We saw that the assessment and management of risk had been reviewed and updated by staff so that people received appropriate support and treatment.

The environment of the home was welcoming and the communal areas were decorated and arranged to make them homely and relaxing and we found that all areas were clean and free from lingering unpleasant odours. We noted some minor maintenance issues needed attention with damaged plaster and paintwork and worn fixtures. These items detracted from the environment but did not present a safety risk to people living there.

We found that there were safe recruitment procedures and practices in place to help ensure staff who were employed were suitable for their roles. All the staff we spoke with knew the appropriate action to take if they believed someone was at risk of abuse. This had been part of the training staff received to be able to carry out their roles. We saw that care staff had received induction training and on going training and development and had supervision once employed.

We found that there were adequate staff on duty during the day. However there was not a formal dependency tool being used to help assess how many staff were needed to meet any changes in people's personal care needs and on night shift.

Medicines were being safely, administered and stored and we saw that accurate records were kept of medicines received and disposed of so all of them could be accounted for. Controlled medicines [those liable to misuse] were in good order.

People knew how they could complain about the service they received and information on this was displayed in the home. People we spoke with were confident that action would be taken in response to any concerns they raised.

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.

There were adequate staff on duty to support people.

Staff understood their responsibility to safeguard people and the action to take if they were concerned about a person's safety.

Medicines were stored safely and records were kept of medicines received and disposed of so all could be accounted for.

Good

Is the service effective?
The service was not effective.

Formal procedures were not in place, in line with the MCA and associated code of practice. Practices were inconsistent when people were having their individual needs and preferences assessed to promote their best interests in line with legislation and recognised guidance.

Staff knew people who lived there well and worked with other agencies and services to help make sure they got the support they needed to maintain their personal needs and preferences.

People had a choice of nutritious meals, drinks and snacks.

Requires improvement

Is the service caring?
The service was caring.

People told us that they were well looked after. We saw that the staff treated people in a kind and friendly way.

Staff demonstrated good knowledge about the people they were supporting, for example detailed information on their backgrounds, their likes, dislikes and preferred activities.

We saw that staff engaged positively with people. This supported people's wellbeing.

Good

Is the service responsive?
The service was responsive.

Assessments of need and individual preference had been undertaken and care plans developed to identify people's health and support needs.

The care plans had been reviewed and updated to respond to any changes in need.

There was a system in place to receive and handle complaints or concerns raised.

Good

Summary of findings

Is the service well-led?

Good

The home was being well led.

People who lived in the home were asked for their views of the service and their comments had been acted on.

Systems were in place to monitor the quality of the service and action was

taken when it was identified that improvements were required.

Maintenance checks were being done regularly by staff and records had been kept.

Bevan House

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 checked 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 15 June 2015 and was unannounced. The inspection was carried out by an adult social care lead inspector.

During the inspection we spoke with eight people who lived in the home, two relatives, four of the care staff, a member of the domestic staff, the supervisor on duty and a registered manager from another of the registered provider's homes who was supporting the new manager. The new manager was not on duty on the day of the inspection.

We observed staff as they went about their duties and interacted with people and supported people in the communal areas of the home. We spoke to people alone and in groups, in private and communal areas. We also spent time looking at records, including looking in detail at seven people's care plans and risk assessments. We did this to help us see how their care was being planned with them and delivered. We also looked at the staff rotas for the previous two months, staff training and supervision records.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We looked a sample of the records relating to the maintenance and management of the service and records of checks being done on how quality of the service provision was being monitored. As part of the inspection we also looked at records and care plans relating to the use of medicines.

Before our inspection we reviewed the information we held about the service. We looked at the information we held about notifications sent to us about incidents affecting the service and people living there. We looked at the information we held on safeguarding referrals, concerns raised with us and applications the manager had made under Deprivation of Liberty Safeguards (DoLS).

Good

Is the service safe?

Our findings

The people we spoke with who were living at Bevan House spoke positively about their home and the staff supporting them. One person told us "They [staff] have always done right by me" and another said "They're [staff] a good lot we have here".

We spoke with people's relatives and friends as they visited the home. They told us that they did not have any concerns about how their relatives/friends were looked after and supported by the staff in the home. We were told by one relative that they felt the home had "Done them a lot of good" and that their bedroom was kept clean and tidy and that "[Relative] is always well dressed, hair done and clean". They told us, "You can't really ask for more at their time of life" and also "I have no worries about them being looked after, but the place is looking shabby and tired now".

We noted that there were areas of the home that needed some redecoration for damaged plaster and paintwork and externally the grounds needed to be weeded and tided and had rusting metalwork and flaking paintwork. These things distracted from the general environment but did not affect people's safety. Despite these things the environment was clean.

People living at Bevan House told us that staff were available to help them when they wanted them. We saw that there were three staff on the two ground floor units as stated on the staff rotas. These were the units where people were living with dementia. At the time of the inspection there were14 people living there and two of these were for short term or 'respite' care and support.

We saw safe recruitment procedures were in place to help ensure staff were suitable for their roles. This included all the required employment background checks and references from previous employers. We saw that equal opportunities monitoring was done during staff recruitment.

The care staff we spoke with told us about the training they had done in recognising and reporting abuse. All the staff we spoke with knew the appropriate action to take if they believed someone was at risk of abuse. They were also aware of the registered provider's procedures for reporting bad practice or 'whistle blowing'. We saw there was information throughout the home for staff, people living there and visitors to refer to on this topic.

The first floor unit had eight people living there as two of the upstairs units were closed. We saw that there were two care staff supporting the people living there. We spent time on the unit and saw that staff supported and joined in with people to take part in activities that had meaning and interest for them.

We found that there was not a formal dependency tool in use to help assess how many staff were needed to meet any changes in people's personal care needs. These kinds of formal tools would indicate good practice as they can assist in formally assessing how many staff might be needed to support people as their needs increased or changed.

We looked at care plans for seven people across the three units that were occupied and saw that needs and risk assessments had been carried out with people. We saw that the assessment and management of risk had been reviewed and updated by staff so that people received appropriate support and treatment. For example, we saw where changes had taken place in nutritional risks for one person management plans had been altered to address the increased risk and monitor weights and make dietary changes.

The risk assessments identified actual and potential risks and the control measures and management plans to help minimise them. People's care plans included risk assessments for skin and pressure area care, falls, moving and handling, mobility and nutrition. Where a risk was identified we could see that action was taken to minimise this.

We looked at the way medicines were being managed and handled in the home. We found that medicines were being safely administered and records were kept of the quantity of medicines kept in the home. We counted a sample of eight medicines and compared them against the records and found all the medicines tallied.

Training records indicated that staff who carried out medicines administration had received training in line with the registered provider's medication policy. We saw that there were arrangements in place in relation to the recording of medicines and that records had been signed correctly on administration.

We looked at the handling of medicines liable to misuse, called controlled drugs. These were being stored, administered and recorded correctly. Medicines storage

Good

Is the service safe?

was neat and tidy which made it easy to find people's medicines. Refrigerator temperatures were monitored and the records showed that medicines were stored within the recommended temperature ranges to help prevent any deterioration of the medicines.

Requires improvement

Is the service effective?

Our findings

The staff we spoke with were able to tell us about the needs, interests and personal preferences of the people they were supporting. People told us the staff who supported them knew how they liked to be supported and always checked with them how they wanted to be helped. We saw that people did receive their care and support promptly. One person living there told us, "I am doing very well, they [staff] know how to look after me properly".

People told us that they enjoyed their meals and that the food was "generally good". We spent time on the units as people had breakfast and morning drinks. We saw that people who needed help with eating received support or prompting in a respectful way. A relative we spoke with told us, "They [relative] have always said the food is good, they seem to enjoy it when I've been here and certainly not losing any weight".

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). The MCA and DoLS provide legal safeguards for people who may be unable to make decisions about their care. We were told by the supervisor that no one living at the home at the time of our inspection had an application to be made under the Deprivation of Liberty Safeguards. The training records showed that all staff had received training on the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA).

We discussed the Mental Capacity Act and Deprivation of Liberty Safeguards with the staff in the home. They had an understanding of the principles involved and what actions needed to be taken for people who might not have the mental capacity to make some decisions had their legal rights protected. We saw that staff at Bevan House were able to communicate well with the people who lived there. We saw that the staff gave people the time to express their wishes and respected the daily decisions they made. We saw that people who had capacity to make decisions about their care and treatment had been able to do so.

We looked at individual care plans to see how people who may not be able to say what they wanted or preferred were supported to be part of their treatment decisions. We looked at the plans in place for some people who had 'do not attempt cardio pulmonary resuscitation' (DNACPR) documents in place. No one had an advance directive on file to indicate particular treatment preferences in the event of not being able to make a decision. We saw that GPs had made clinical decisions as to whether or not attempts at resuscitation might be successful.

We found that the information on file for decisions made around resuscitation was not of a consistent standard or supported by formal and person centred record keeping. For example, there were DNACPR forms that had been completed by doctors that stated a team discussion had taken place around this or following a 'best interests meeting'. However, there were no records of that or any records of formal best interests meetings where a person's capacity to make or be involved in a decision was in doubt.

There was no formal procedural guidance on the organisations' agreed best interest processes to guide registered managers and staff. Such guidance helps to make sure staff can formally and consistently act collaboratively with people or their lawful representatives across the organisation. For major treatment decisions this process needed to be in place to provide evidence in line with the MCA and associated codes of practice and place people at the centre of decision making.

We noted that the information around who held Power of Attorney for a person was not always clear in people's care plans or if there was evidence seen of the authority. Powers of Attorney show who has legal authority to make decisions on a person's behalf when they cannot do so themselves and may be for financial and/or also care and welfare needs. It was not always clear which of these applied. As a result it was difficult to know who held legal authority to make decisions about health and welfare on someone's behalf or if this was just for finances.

These practices were not placing people at the centre of decisions affecting their treatment. Decisions being made about treatment options that were based upon an assessment of the mental capacity needs and assessments were not being carried out collaboratively or with lawful representatives. The lack of guidance for staff led to an inconsistent approach to person centred care and advance care planning.

This indicated a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because formal policies and procedures were not in place in line with the MCA and associated code of practice. Staff had not consistently assessed people's capacity and

Requires improvement

Is the service effective?

ability to be involved in decision making and give consent in line with legislation and associated code of practice. Assessment practices were inconsistent when people were having their individual needs and preferences assessed to promote their best interests in line with legislation and recognised guidance.

We saw that people's care plans had a nutritional assessment in place and that their weights were monitored for changes so action could be taken if needed. We saw that advice had been sought from the dietician or the speech and language therapist (SALT) if a person needed this and the information received was in their care plan. There was also information on specific dietary needs such as diabetic diets and soft and pureed meals as well as where people had dietary intolerances. This information was recorded in the care plans.

Staff and the supervisor we spoke with told us that they thought they were given access to appropriate training and induction to carry out their work. Training records we saw indicated that staff were supported to do the training relevant to their roles. We could see from records and care staff told us that they had done a lot of training in preparation for the move to the new home. This had included team building training as staff moving to the home would come from different homes.

Care staff also confirmed that they received regular supervision from the supervisors and records supported this and that staff had received an annual appraisal. We could see that staff training was being monitored and planned for by the across the year as it fell due for people.

Good

Is the service caring?

Our findings

All the people living at Bevan House that we spoke to and the relatives we spoke with made positive comments about the staff approaches and the care and support provided to them in the home. People living there told us they decided what they wanted in their daily lives and told us that they felt able to tell staff how they wanted to be supported and how they wanted to spend their time. One person living there told us, "I am doing very well, they [staff] always do their best for you". They also told us that the staff were "Very kind" and "They [staff] have the patience of Job".

Relatives we spoke with told us there were no restrictions on their visiting and one old us they had found the care staff to be "attentive" and "kind" and that all the staff were "Very good to [relative], the slightest thing and they let me know what's happening".

During our time with people on the three units we saw that the staff offered people assistance but respected their independence. We saw that staff took the time to speak with people and took up opportunities to interact with them, engage and offer reassurance if needed. We saw that care staff actively supported people to take part in daily tasks such as, setting the tables for meals, helping with washing up, helping with the morning coffee. These things promoted people's independence and can enhance their social wellbeing.

We used the Short Observational Framework for inspection, (SOFI) to observe how people in the home were being supported and were spending their time. We joined people living with dementia in a communal area of the home. We saw that people who could not easily tell us their views were comfortable and relaxed with the staff that were supporting them. We saw staff talking to people in a calm and friendly manner and called people by their preferred names as stated in their care plans. We saw that people were being supported to make sure they were appropriately dressed and that their clothing was arranged properly to promote their dignity.

We saw that staff promoted people's privacy by knocking on bedroom and bathroom doors before they went in. Everyone's bedrooms at the home were for single occupancy and this meant that people were able to spend time in private or see people in private if they wished to. Bedrooms we saw had been made more personal places with people's own belongings, such as photographs and ornaments to help them to feel at home with their familiar and valued things

We found that information was available for people in the home to help support their choices. This included information about the services offered, about support agencies such as advocacy services that people could use. An advocate is a person who is independent of the home and who can come into the home to help support a person to share their views and wishes.

Some people needed pieces of equipment to help them maintain their independence. We saw that the staff knew which people needed pieces of equipment to support their independence and provided these when they were required.

Training records indicated that most of the care staff had done some training on supporting people with bereavement and loss to help support people with this difficult issue. There was information in the home to access palliative care nurses if needed with any difficult end of life issues. Staff we spoke with understood how important person centred care was when caring for people coming to the end of their lives. They told us that the district nurse and a person's GP supported and advised at that time.

Good

Is the service responsive?

Our findings

Information on people's preferred social, recreational and religious preferences were recorded in individual care plans. We spent time on the units and saw that staff supported and joined in with people to take part in activities that had meaning and interest for them. On the first floor unit we saw people playing Scrabble and chatting with the staff and sharing a joke. One person told us they saw the care staff as friends and told us, "They're my mates, we can have a laugh about things, I play hell with them and keep them on their toes".

All of the people living at Bevan House we spoke with told us that routines in the home were flexible to meet their needs and choices about their lives. We were told that when there had been a hot day recently people had decided to sit out on the patio and have hot dogs for tea. We were told it was too short notice for a barbeque so they had "made do" with hotdogs. We saw on all three units that there was a lot of chatter and 'banter' between staff and people living there and staff knew people well enough to talk about their families, former jobs and history in the local area.

We looked at the information in people's care plans about how they wanted to be supported and saw their preferences were clear for staff to be aware of. For example how people wanted to dress, what they wanted to drink when they first woke up.

People told us they chose where to spend their time, where to see their visitors and how they wanted their care to be provided. We found that people were able to follow their own beliefs and faiths and see their own priests and clergy as well as take part in religious services. We spoke with people who had already been out that morning, one with staff for a walk to the local shops to get items they wanted and another person had been out to town using their mobility aid.

None of the people who lived in the home, their visitors or the staff we spoke with raised any concerns about the quality of the care. People told us they had no complaints at the moment but knew who they could complain to if they were not happy about something, "I would tell the supervisor". There were complaints forms available in the reception area and a log was kept of any received and how they were dealt with. Relatives we spoke with told us they had "no concerns" but that if they did they would "go to the office" and tell senior staff.

People's health and support needs had been assessed before admission and we saw that people living at Bevan House had access to health care professionals to meet their individual health care needs. The care plans and records that we looked at showed that people were being seen by appropriate professionals to help meet their particular physical, nursing and mental health needs. We saw records in the care plans of the involvement of the community mental health team, district nurses and specialist nurses as well as opticians, chiropodists and dental services.

We saw that everyone living at Bevan House had a 'hospital passport', this had information about the person, their health and care needs, medication and what they wanted in order to support them. This information was to help make sure that should a person need to transfer to another care setting quickly all the relevant information would be available that staff would need to provide support on arrival.

The information gathered before and on admission had been used to develop individual care plans. We saw information had been added to plans of care as they were developed and as the persons preferences and wishes became known. Records indicated that reviews had been carried out on people's assessed needs and associated risks. People we spoke with confirmed to us that they knew there was a plan about them. We saw that where possible people had signed their own care plans to agree the plans in place.

Good

Is the service well-led?

Our findings

People we spoke with who lived at Bevan House told us they felt they were kept "up to speed" on what was going on in their home. For example they told us they were kept well informed about the planned move to the new home that was being built to replace Bevan House. People told us that they were looking forward to the move and had been told what the facilities would be for them at the new home. Records of 'residents meetings' showed this had been discussed and also everyday things like new Summer menus and who did not want beans on toast anymore.

The service did not have a registered manager in post, as required by their registration with the CQC, at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. It had been anticipated that the home would have closed and moved to the new premises in Spring so the registered manager post had been vacant. When it became evident there would be a delay in closure the registered provider had recruited a suitable person who was in post and in the process of registering as the manager with CQC.

There were also records of the staff meetings being held in the home. This helped to give staff the opportunity to raise issues and discuss practice and care matters and promote communication about what was going on. They had also discussed the move and the reasons why it had been delayed. Staff told us that the new manager in post was approachable and they knew them well from their previous role as a supervisor.

People we spoke with told us that they felt that this home was being well run for them. People who lived in the home and their visitors said they knew the new manager well as they had been at the home a long time as a supervisor.

There were systems in place to assess the quality of the services provided in the home and records of the checks made. We saw that audits were done on care plans and medication records on a monthly basis. We also saw that staff had done annual competency checks to make sure their medication practices were up to date. This was to help make sure that information was accurate and up to date and that the correct procedures were being followed by staff. We saw that records of cleaning routines were also checked to help make sure the cleaning schedule had been followed and to help make sure the premises and equipment were clean and safe to use.

The registered provider carried out their own annual internal quality audits and health and safety audits against their own policies and procedures. There were also regular visits from the operations manager for Cumbria Care to do their own checks on aspects of the service and monitor the standards in the home

We looked at the records of accidents and incidents that had occurred in the home on the units. We did this to check if action had been taken promptly to reduce the risk of it happening again. We saw that incidents had been recorded and followed up with appropriate agencies or individuals and, if required, CQC had been notified. Maintenance checks were being done regularly by staff and records kept. Faults had been highlighted and acted upon to get repairs done and these were recorded. There were cleaning records to help make sure the premises and equipment were clean and safe to use.

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 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The registered provider did not have procedures in place in line with the Mental Capacity Act and the associated codes of practice for staff to follow to consistently assess people's capacity and ability to consent in line with legislation.