United Care limited

Bescot Lodge

Inspection report

76-78 Bescot Road
Walsall WS2 9AF
Tel:01922 648917
Website:

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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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced inspection of this home on 8 January 2015. Bescot Lodge is a residential home providing personal care for up to 26 older people who may have dementia. There were 20 people living at the home when we inspected.

At the last inspection in June 2013 we asked the provider to take action to make improvements to the premises. Following this inspection the provider sent us an action plan to tell us the improvements they were going to make by December 2013. We found improvement's had been made during this inspection.

It is a requirement that the home has a registered manager in post. The registered manager left the home in June 2014. We were made aware of this by the provider but an application to remove their name from the register has not been received. A new manager was appointed to the home in November 2014. A registered manager is 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 2008 and associated Regulations about how the service is run.

Summary of findings

People did not get the support they needed at times because there was not enough staff on duty to meet their needs. You can see what action we told the provider to take at the back of the full version of the report.

People felt safe living at the home. Staff know how to identify abuse and how they should report it.

Risk assessments are completed but do not always contain the most current information about a person.

Not all staff had received training to ensure they had the skills to support people's needs.

Staff have limited understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). There was a risk that people's rights would not be appropriately supported.

People have to wait for their care and their preferences are not always respected. Staff are kind, caring and respect people's privacy.

People are not included when activities are planned. There are few activities for people to take part in that are centred around their own individual hobbies and interests. Visitors told us they felt welcome at the home which meant that people were able to maintain relationships.

The leadership needs to be improved and there is a new manager in post.

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 always safe.

People did not get the support they needed at times because there was not enough staff on duty to meet their needs. People were kept safe because staff understood how to recognise abuse and take action to protect them. The provider needed to make improvements to the environment so people could be comfortable.

Requires improvement

Is the service effective?
The service was not always effective.

Staff did not understand the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. There were some gaps in staff training which was being addressed. People felt supported to access healthcare services and external appointments.

Requires improvement

Is the service caring?
The service was not always caring.

Interactions between staff and people were caring. Opportunities for positive interactions were sometimes missed by staff. Staff did not always demonstrate respect for people's dignity. People felt their privacy was respected.

Requires improvement

Is the service responsive?
The service was not always responsive.

Care plans did not always provide consistent information about people's needs. Some people participated in activities other people received little stimulation throughout the day. People felt confident any complaints would be listened to and resolved to their satisfaction.

Requires improvement

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

People, relatives and staff were complimentary of the new manager and felt concerns would be listened to and issues addressed. Audit systems were not always effective to monitor the quality of care provided. The provider did not carry out a robust analysis of accidents and incidents to identify trends.

Requires improvement

Bescot Lodge

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 8 January 2015 and was unannounced.

The inspection team consisted of one inspector and one expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of supporting a family member who used residential care services.

Before our inspection we reviewed information we held about the home including information of concerns. We looked at statutory notifications sent by the provider. A statutory notification is information of events which the provider has to notify us about by law. We also contacted the local authority to gain their views of the service.

We spoke with six people who lived at the home and four relatives. We spoke with two care staff and two managers. We looked at four records relating to people's care, medicine records and records relating to the management of the home. We also looked at staff recruitment records and training documents.

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 with us.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they did not always receive care and support when they needed it. One person told us, "It can be anywhere between a few minutes or not at all I think blow it, I'm going to the toilet on my own. I get told off because I'm not supposed to." Three people told us they felt there should be more staff particularly at night as they sometimes had to wait for someone to come and support them. One person told us they normally waited a few minutes for someone to respond but if staff were busy it could be longer. Another person told us they liked to go upstairs to lay on the bed but had difficulty getting upstairs but staff tried to put them off going upstairs by suggesting they go later in the day. The person told us, "The one thing that does upset me is when I want to go to the toilet, I have to wait they make you feel like you shouldn't be calling for help when you want to go the toilet, you don't want to wait twenty minutes." One relative told us, "I think my [person's name] does have to wait sometimes." Another relative told us they thought their relative received care when they needed it but told us, "Sometimes the toilet's a problem as [person's name] wants to go when it's teatime when it's busy."

On two separate occasions during our inspection we observed one lounge area did not have any staff present for periods of time. On both occasions staff had to be called by us to assist people who required support. The first instance a person was observed walking across the lounge and trying to sit down on the lap of another person. In the second instance a person was shouting for help because they were slipping off their chair. We observed during the lunch time period people were kept waiting for up to half an hour for their meal and longer if they required assistance.

The number of staff working on shift during our inspection was in line with the provider's staffing rationale tool. However, the manager was reviewing the care needs of people who lived at the home to identify if there had been any changes.

We found that the registered person had not protected people against the risk of insufficient numbers of suitable, qualified, skilled and experienced persons employed to meet people's needs. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at the home. One person said, "Yes I feel safe." Two visitors told us that they felt their relative was safe and one relative said "Fairly, as far as I know".

Staff we spoke with were able to identify different types of abuse and actions they should take to keep people safe. Staff told us they would report concerns to the manager and would expect them to follow the correct safeguarding process. Staff were aware of which external agencies to escalate concerns if necessary. Staff told us that they were aware of the need to 'whistle blow' on poor practice if required and felt confident to do so. Whistleblowing is the term used when someone who works for an employer raises a concern which harms, or creates a risk of harm, to people who use the service. We observed that there was no information displayed within the home on how to report abuse this meant there was a risk that people who did not work at the home would not know how to report allegations of abuse. However, relatives we spoke with told us they would report concerns to the manager.

Staff demonstrated an awareness of people's care needs and risks. We observed staff supporting people to walk. We saw staff ensure people took their time, moved in a safe way and were patient when assisting people. We looked at four people's risk assessment records and found they were different for each person. We saw that risk assessments were reviewed monthly. However, two people had sustained recent falls within the home. This information had not been used to update the risk assessment in relation to the increased risk associated with their mobility. Staff told us information about changes in people's care needs was given during handover between shifts and they were aware of people who were at risk of falls. We saw a communication book used by the senior care staff to share information between shifts. This information is cascaded to care staff therefore ensuring staff have knowledge of changes in people's needs and risks.

We looked at incident and accident records and saw that staff reported these appropriately. One record detailed an injury sustained by a person while using a sling hoist. The

Requires improvement

Is the service safe?

manager was able to give details about the event and actions taken to reduce the risk of it happening again. The manager observed and monitored staff practice and arranged additional training in moving and handling.

We spoke with the relative of this person, they told us that the manager had informed them of the incident when it happened and of the actions they had taken to reduce the risk of it happening again. The relative was happy with how the incident was handled and actions taken by the manager.

We looked at the process followed for the recruitment of new staff. We saw evidence that appropriate employment checks were completed on new staff. This meant the provider has ensured staff had the required checks prior to starting work at the home.

One person told us, "I get my tablets on time but I do find it daunting when I wake up at one am with a migraine and I can't find anyone to give me paracetamol because it has to be someone capable of giving medicines even though the doctor says it's on the list and I can take it through the night with the four or five hours in-between." We spoke with the manager about this who said that they would in investigate. All people we spoke with told us they were given their medicines on time. Relatives we asked told us they did not have any concerns with how their relative medicines were managed. One relative told us "The care home has it under control."

During this inspection we looked at the medicine records for two people. We found no gaps in recording. However, we compared their medicine records to the stock levels to calculate remaining stock. This was so we could calculate if the correct amount of medicines had been administered. We found that in one instance the stock level did not correspond with the records. We informed the manager so that they could investigate the error. We observed one medicine round and saw this was done safely.

We found some people were prescribed 'as required' medicines to be taken only when needed, for example for pain relief. We saw people had records in place giving direction of how and when 'as required' medicines should be given. We saw that records did not have a review date. Staff told us the records would be reviewed when a person's medicines were reviewed. The manager informed us that review dates and signatures would be added to the records.

Requires improvement

Is the service effective?

Our findings

One relative told us that they thought staff had the skills and knowledge to meet their relative's needs and that they had no complaints about the way their relative was looked after. Staff we spoke with were able to inform us of people's specific support needs. We observed positive interactions between staff and people who lived at the home and people told us they were happy with the care that they received.

Staff we spoke with told us they felt confident in their roles and that they had received enough training to meet the needs of the people who lived at the home. We looked at records which showed that not all staff had received training in the areas considered necessary for them to carry out their roles safely, such as moving and handling and safeguarding. We saw gaps in staff training were being addressed and outstanding training had been arranged.

Staff told us they had received one to one meetings with the manager and were able to discuss their training needs and performance during these meetings. Staff also told us they attended group meetings with the manager to discuss improvements in care for people who lived at the home. We spoke with the manager during our visit. They acknowledged there were performance issues with some staff which had not been addressed previously. The manager had now undertaken to address these issues and informed us that they were looking at staff's capability and offering additional training and support where required.

We saw people were free to move around the home and we did not see any restrictions put on people during this inspection. We saw staff had not received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). MCA sets out how to act to support people who do not have capacity to make a specific decision. DoLS are safeguards used to protect people where their liberty to undertake specific activities is restricted. Staff we spoke with were unclear about the implications of these such as in terms of people's capacity to make decisions. The new manager and staff we spoke with told us they were not aware of anyone living at the home subject to a current DoLs arrangement. However, the supporting manager told us there was one person living at the home with a current DoLS arrangement in place. We looked at the record for the authorised DoLs and saw the decision was fully documented and authorised. There was a risk that the person safeguarded by an authorised DoLs would not be protected by these provisions being correctly followed by staff.

All the people we spoke with told us that they enjoyed meal times. One person told us the food was, "Pretty good." Another person told us, "Food isn't bad the cook here is a treasure. If I ask them to do something, she goes out of her way to do it." One relative told us, "They seem okay [Person's name] seems to enjoy them."

People were encouraged to eat their meals in the dining room. We saw that meal time was not a positive experience for some people. Menus were not available in the dining room, however we did see staff offered people a choice of two hot meals. One person refused both options and was offered sandwiches as an alternative. We saw people were not offered a choice of drinks unless specifically requested. We observed people were waiting up to 20 minutes for their meals to arrive. One person waited a further 20 minutes before a staff member approached and offered support to eat their meal.

One person was offered no meal choice and was given a plate of mashed potato and vegetables. We spoke with the manager who informed us this person was vegetarian. The manager was aware of the person's nutritional needs and told us alternative food had been encouraged but was refused. The manager told us they were currently investigating alternative food options.

One person told us "If there's an emergency they will get the doctor in." Another person told us that they were due to go to a non-urgent appointment, but had decided they did not want to go out, the senior carer was arranging for the doctor to come into the home instead. Records confirmed that people received the support of external healthcare professionals to maintain their health. For example we saw that a person had been referred to the GP for a mental health assessment. This showed that the home involved other professionals where appropriate to meet people's needs.

Requires improvement

Is the service caring?

Our findings

People told us staff were kind and caring. One person told us, "They speak to me normally, how you would expect people to speak to you." Relatives we spoke with told us staff seemed caring. One relative told us "They're pretty good." Another relative told us, "Yes, the ones I've come across, definitely are." We observed interactions between staff and people and saw that people were relaxed with staff and felt confident to approach staff throughout the day.

We saw that most staff communicated effectively with people and maintained eye contact when they spoke with them. We observed that staff had a good rapport with some people but did not communicate well with all people. We saw members of staff joking and laughing with people. One person commented staff are, "Great, we have sarcastic banter. We can have a laugh." We observed one person who was not able to verbally communicate with people. We observed staff providing care to this person. We saw that staff were kind and patient speaking clearly and maintaining eye contact. However we saw that staff only engaged with this person when delivering care needs and not at other times. The manager acknowledged this was an area which required improvement.

One person told us, "I get up mainly when I am told to they come in and wake you." Another person told us, "You have to get up the normal time, round six, to have a wash and go down for your breakfast." Most people told us they did not have a choice what time they got up. However people we spoke with told us they could choose what time they went to bed. One person told us, "I stop up if I'm watching a programme; I could be up until eleven." We asked people whether they were involved in their care planning and if they were able to express their views about the care they received. People told us staff spoke to them and their relatives about their needs. We spoke with four relatives who told us they had been involved in the planning and decisions about their relative's care and had been able to give their opinion on how support and care was provided. Relatives told us that staff kept them informed of any concerns or incidents.

People were supported to be as independent as possible and encouraged to do as much for themselves as they were able to do. One person told us they were supported to get up and use their frame to walk to the toilet. We observed a person at meal time being given a fork and saw a member of staff support and encourage them to eat independently.

People told us their privacy and dignity was respected. One person told us, "They knock on the door." Another person told us, "Some of them do respect and others don't." We spoke with four relatives and they all told us their relative's privacy and dignity was respected by staff. We observed staff members knock on people's door and wait before entering; we saw that doors were closed when personal care was given. We observed one staff member continue with a non work related conversation with another staff member when serving lunch to a person. On another occasion we heard a member of staff ask a person if they needed to go to the toilet in a way that did not maintain their dignity. We observed at meal time people were not offered a choice of drink one person told us, "They come round and say we know coffee, two sugars. They seem to know what you have and what you like." Staff we spoke with gave examples of how they would respect a person's dignity such as ensuring a person's dignity was protected when being hoisted.

Requires improvement

Is the service responsive?

Our findings

One person told us care is provided, “When it’s convenient for them.” [Staff] Another person told us, “Depends on what they’re doing. Normally it’s only a few minutes but if they’re busy it could be longer.” Other people told us they were happy with the responsiveness of the service.

We saw that people were encouraged to sit in one of the two lounge areas during the day. We observed no activities and little interaction with staff during the morning. One person we spoke with told us there were not many activities. Another person told us, “They’ve a gym session. I’m against that. They keep asking me.” We observed people sitting in chairs for long periods of time with no stimulation. There was a reminiscence room on the first floor however during our visit we observed no one using the room. One person told us they were discouraged from going upstairs. One staff member told us people were encouraged to come down stairs so that they could be monitored better. Staff we spoke with told us a variety of activities took place at the home for example sing along and exercise classes. During the afternoon an entertainer attended and performed to a group of residents. The manager acknowledged this was an area which required improvement and was developing activities that met the differing needs of people living at the home.

People told us visitors were welcomed most times of the day. One relative we spoke with told us visiting was “Pretty flexible.”

We looked at four care records and saw people’s care needs had been assessed and were reflective of people’s needs. Individual care plans had been produced in response to risk, such as falls. However, where changes in people’s care need had occurred these were not always reflected in the care plan or risk assessment. Staff were made aware of changes in people’s care need via shift handover meetings and a senior care communication book.

People we spoke with told us they would be confident speaking to staff or the manager if they had any complaints or concerns. One person told us, they hadn’t had to complain but said “I’d have to ask for the manager.” Another person told us, “I’d wait for my visitors to come.” Relatives we spoke with told us they would contact the manager if they wanted to raise any concerns. One relative told us “I would go and see [person’s name] who is the home manager.” We looked at the complaint’s log and saw issues had been raised and dealt with appropriately. We saw there were no current complaints. There was no complaints information on display within the home. The manager informed us a notice board was going to be put up in the corridor. We were told this would be completed by March 2015.

Requires improvement

Is the service well-led?

Our findings

During our inspection in June 2013 we found the provider was not protecting people against risks associated with the premises by ensuring the home was maintained adequately. The inspection found a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider sent us an action plan outlining how they would make improvements.

We found improvements had been made which were identified in the action plan. We saw that the general décor of the communal areas were in need of updating and some areas of flooring were stained. We noticed an unpleasant odour in one of the lounges. We saw that bedrooms had been decorated and found the cleanliness of rooms were good. We requested to see the homes refurbishment plan to better understand how the provider had prioritised maintenance and future refurbishment to the home. We saw that the manager had identified areas in need of refurbishment and had completed a plan for work to be completed during 2015.

The home does not have a registered manager in post. However, a new manager has recently been appointed in November 2014. The manager was aware of our requirement to apply for CQC registration. They informed us they would commence the process once they had completed their probation. People told us they found the manager approachable and pleasant. One person told us, “The manager is very nice, very considerate.” Staff informed us that the new manager was approachable and supportive and the atmosphere of the home had improved since they had been appointed. The manager was aware the home had been through a difficult period however, was clear what was required to move the home forward. The manager told us one of the biggest challenges was addressing staff culture and supporting staff to move forward. The manager told us support was being provided by senior managers from the organisation. We saw that the home had a clear management structure in place and the manager had an ‘open door’ management style we saw that staff and relatives felt at ease to approach and ask for advice and support as required.

We found the manager provided leadership and guidance to staff and was clear about the standard of service they wanted to provide to people who lived at the home. The manager had completed a number of staff meetings to address immediate issues and conducted one to one meetings with staff. The manager had worked with staff to identify training needs to enable staff to meet people’s needs. The staff we spoke with were happy with the level of support they received from the manager. The manager told us they were introducing a number of new systems in the home such as a key worker system. A keyworker is a named member of staff who works with the family and acts a link with their family. The manager informed us that they were looking at developing activity diaries and purchase activity resources to meet the differing needs of the people living at the home.

We looked at the quality audit systems and found that arrangements were in place to assess and monitor the quality of the service provided. Information was inconsistent and did not identify some of the concerns we found during our inspection. For example care plans contained inconsistent or out of date information. We looked at incident and accident records and saw that information was collated but information was not analysed to identify trends or recurrent risks.

We saw that the manager had identified a number of areas for improvement in the service in the short time they had been in post. However, further work was required to ensure that the improvements became embedded and understood by all the staff. We looked at how the provider obtained people’s views of the home. We saw that there had not been any recent resident or relative meetings or survey’s completed. One relative told us “I don’t think it has been well managed. I hope now the changes are in place it will be.” There was currently no system in place to listen and respond to the views of people or their relatives to help improve the service provided. The manager informed us relative and relative meetings would be arranged.

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 18 HSCA (RA) Regulations 2014 Staffing We found that the provider had not taken sufficient steps to ensure that there was enough numbers of suitably skilled and experienced staff to meet people's needs.

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.