Barchester Healthcare Homes Limited

Stamford Bridge Beaumont

Inspection Report

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Contents

Summary of findings

Overall summary

Stamford Bridge Beaumont is a care home which offers nursing and personal care for up to 107 people. Some of whom were living with a dementia type illness. The home is situated in Stamford Bridge, which is a village in the East Riding of Yorkshire, close to the City of York. Accommodation is provided over three floors in a Georgian listed building and purpose built extension. The home is divided into five main areas with three of these being used to support people with dementia. The registered provider is Barchester Healthcare Homes Limited. At the time of our visit 80 people were accommodated in the home.

There was a registered manager in post at the time of this inspection who had been registered with the CQC since January 2013. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the MCA (Mental Capacity Act 2005) legislation which is in place for people who are unable to make decisions for themselves. The legislation is designed to ensure that any decisions are made in people's best interests. We found that correct procedures were followed if anyone had needed to be referred regarding any Deprivation of Liberty Safeguards (DoLS) queries.

We found there were assessments in place to help people be safe, live their lives as they chose whilst minimising risk and to be supported by the right numbers of staff. However, we noted that staff were not always risk aware and observant, sometimes being focussed on tasks rather than people. This meant that care was not centred on the individual and their needs.

People had some involvement in their assessments to help make sure their needs were known by the staff. People told us their choices were recorded and that they had access to health professionals. However we found inconsistencies in the meeting of people's health needs.

The level of support people received and the activities available to people varied in the different areas of the service. This meant that care and support people received was not consistent.

However, people told us they liked the staff; felt listened to and their choices were respected. People and their relatives were consulted about their care at regular meetings.

People told us that the registered manager was approachable, knew the needs of people who lived in the home and chatted with people. The quality of the service was checked regularly through the use of audits. The management used the audits to help identify areas of improvement. However, during this inspection we found that some areas and practices in the home required improvement.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that the home was not always safe for people as there were inconsistencies in practice regarding risk. For example, staff did not make sure people were sat safely in their wheelchairs.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the MCA (Mental Capacity Act 2005) legislation which is in place for people who are unable to make decisions for themselves. The legislation is designed to ensure that any decisions are made in people's best interests. We found that correct procedures were followed if anyone had needed to be referred regarding any Deprivation of Liberty Safeguards (DoLS) queries.

We saw that people who were confused or upset received the appropriate support from staff.

Are services effective?

People did not always receive effective support. People were not always referred to specialist for support in the meeting of their needs. People's records had gaps; this meant there was the risk that the person's needs were not met.

People's needs were assessed and people told us that they were able to express their choices. Information regarding advocacy support was available.

People's needs and likes in relation to their diet were known. But we found that support for people at mealtimes was inconsistent. We saw in one area of the home poor practice in relation to peoples support with their meal.

Are services caring?

People told us that the staff were caring and 'Lovely"; they said that they respected and listened to them.

People were not always supported correctly with their personal appearance and dignity. Although we saw that staff were respectful, they knocked on people's bedroom doors and were discreet when offering personal support.

People's needs in relation to end of life care was clearly recorded in their care plans. This helped staff to meet these needs. Specialist support was also arranged, for example, Macmillan nurses.

Summary of findings

Are services responsive to people's needs?

The service was not always responsive to people's needs. Although people's interests and hobbies were assessed, these were not always provided.

People told us they felt that staff listened to them; they felt able to raise concerns. Not everyone was aware of the correct process to follow with a concern.

We saw that people were supported to make decisions and that, when necessary, their capacity for decision making was assessed.

People were also supported to maintain important relationships and we saw that people received visitors throughout our visit. However activities or pastimes were not available to everyone.

Are services well-led?

There was a registered manager in post and we saw that they were approachable and knew the needs of the people who lived in the home. However, the service was not well led as people's needs were not always met. We found that people were not always kept safe from harm. Additionally staff training required improvement.

We saw there were development plans in place and that quality assurance checks were taking place. However, these had not been effective as there were inconsistencies in the home for example, with managing risks.

People were consulted through the use of questionnaires and the results from these were available. We saw that meetings took place for people's relatives, friends and staff to help make sure people were fully informed and consulted.

Summary of findings

What people who use the service and those that matter to them say

We spent time talking with people who lived in the home. When we asked about staffing and safety people said, "I feel very safe here; if you have a problem you'd be quickly found",

"They're all lovely people" and "They're very pleasant indeed." However, another person told us, "I need a lot of help, it can be 15 minutes wait when I ring - too often for my liking",

We also asked people about their plans of care and access to health care, they told us, “I know that they had a meeting with someone who works here and my son & his partner. I think they were talking about me staying here and how I was." One person was very clear, saying “There are regular discussions on my care and any changes. You feel you can always tell someone and something will be done.”

We also asked people about activities, one person said, “If you want to join in something you can. I've done Scrabble and an exercise class, but if you want to be alone then you can."

When we asked people if they felt able to raise any concerns we were told, “I don't have any concerns at the moment but if I did I'd feel able to raise it with someone, I don't know who though." Another person said "Yes, you can raise it with anyone and it gets sorted."

Stamford Bridge Beaumont

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 of the Health and Social Care Act 2008. It was also part of the first testing phase of the new inspection process CQC is introducing for adult social care services.

The inspection team consisted of two inspectors and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of care service

The service was last inspected by the Care Quality Commission on 15 October 2013 and we found they were meeting all of the standards covered during the inspection.

Before the inspection we reviewed the information we held regarding the service. This included any notifications they had forwarded to us about incidents in the home. We also reviewed information we had received from other people including relatives and commissioners of services.

During the inspection we spent time on different units within the home and spoke with people who lived in the home, staff, managers and visitors. This included discussions with the registered manager, one member of training personnel and three nurses and care staff. We reviewed documentation held. This included seven care plans for people who lived in the home, duty rotas, staff training records, menus and policies and procedures.

We spent time with people who lived in the home and observed the support they received. We saw how people and staff interacted. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Are services safe?

Our findings

We asked people who lived in the home if they felt safe and they told us "There is a good feeling of security" and “I feel very safe here; if you have a problem you'd be quickly found".

We looked at staff training records and saw that levels of training varied across the units in the home. We found that staff had completed the required or mandatory training. Records viewed recorded that few staff had received training relating to individual needs for example, dementia care. However, the provider informed us that 89 of the 102 staff had received this training.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the MCA (Mental Capacity Act 2005) legislation which is in place for people who are unable to make decisions for themselves. The legislation is designed to ensure that any decisions are made in people’s best interests. The registered manager explained how they made sure people’s rights were protected. They told us about the Deprivation of Liberty Safeguard (DoLS) and that no-one who lived in the home had been subject to this. They told us that some people in the home had their capacity to make decisions assessed. One person’s file included an assessment in relation to their capacity and another person had been referred for a DoLS assessment. However, we found that not all of the documents were signed. We looked at staff training records and spoke with staff about how they helped protect people’s rights. We found that not all staff had been trained to make sure they followed the correct framework.

People’s files held some information in relation to a Lasting Power of Attorney (LPA). The registered manager told us how they copied these documents and held them on file. This was to make sure staff were fully aware of the content. An LPA is a legal document which allows someone to appoint another person to make decisions on their behalf. This can be in relation to health and welfare or property and financial affairs, or both. This enabled staff to respect people’s wishes.

We also looked at the systems and training in place to help protect vulnerable people from harm. This included the actions staff would take should an allegation of harm be raised. We found that systems were in place and all of the staff had received this training. This included care workers, administrators, cooks and housekeepers. Which meant that all staff in the home were aware of issues of safeguarding. This helped people be safe.

People’s care plans included a variety of risk assessments. These helped people live their life safely and maintain their health. People’s risk assessments included risks associated with mobility, moving and handling, nutrition and hydration. This helped staff manage potential risks whilst people lived their lives as they wished.

We observed that not all staff were fully aware of risks. We saw two people were left in wheelchairs in the lounge after being taken there in readiness to play Bingo. We saw that both fell asleep and one person slipped down in their chair. Staff were not aware of this risk until we raised the concern. Staff then responded appropriately and people were assisted to sit in armchairs. However, we also saw that some staff were aware of risks. Staff made sure hot drinks were not placed dangerously and they were alert to people’s care needs. People were not fully protected from harm due to these inconsistencies in practice.

We looked at the support people received in relation to their mental health, cognition and ‘behaviour’. People’s needs were recorded in their care files. This included information regarding short term memory loss, levels of confusion and any impact on their mental health. Peoples care plans included information which advised staff how to manage people’s behaviours. For example, one care plan stated, “To reduce altercations”. It then described the actions staff should take to be aware of and to make sure the person’s needs were met. People were supported by staff when they were confused or distressed. People were offered the appropriate distraction techniques by staff to assist them to remain calm and reduce any stress.

Staffing levels were organised through duty rotas to help make sure there were sufficient numbers of nursing and non-nursing staff available. We saw duty rotas that evidenced ancillary staff were employed. This included administrators, catering staff, housekeepers and laundry staff to support the meeting of people’s needs. Care and nursing staff levels varied in each unit and these reflected staffing based upon people’s assessed needs. People who lived in the home gave us differing opinions about staffing. One person said “According to ‘them’, there's never enough", another said "I need a lot of help, it can be 15

Are services safe?

minutes wait when I ring - too often for my liking". Whilst others commented "There's always someone around" and "Always enough (staff)". However, one staff member told us they felt there should be more staff.

Are services effective?

(for example, treatment is effective)

Our findings

People were positive about their freedom of choice in all aspects of their day to day care. For example, they told us “I get up when I like and I go to bed when I like", “If I don't want something or want to do something then I won't, it's not hard" and "Sometimes I'll have toast and marmalade but sometimes I might want some bacon. I have what I want and you can get it at what time suits you best ".

People’s files included information regarding their choices and preferences. For example, people’s preferred ‘first contact’ was recorded and in some instances this was a friend not a relative. This offered people the opportunity to name who they would like the home to contact if they were unwell. People’s care files also recorded what choices they had made and how these had been respected. This included for example, when they chose to decline an activity. This evidenced that people’s choices were known and respected in the home.

People’s needs were assessed before they moved in to the home. This helped to make sure that staff were aware of the person’s needs and choices. We saw that this included consultation with other agencies and relatives to make sure a full picture of the person’s needs were gained. However, in one instance a person’s relative had not been easily contactable and there were gaps in the information in the person’s care file. Consequently, the service may not have had all the information they needed about the person. We also saw that people’s care plans recorded their health and support needs but again on occasions there were gaps. This did not make sure that staff were fully aware of the person’s needs.

People told us about their care plans and assessments and how they were involved in these. The majority of people were not aware of the documents but they could recall their assessments. They said, "I had a meeting with someone who works here and my son & his partner. I think they were talking about me staying here and how I was" and “Oh, my son sees to all that."

One person who came to the home from hospital told us “Anyone looking for long stay accommodation would have a job to better it anywhere". They said the move "Wasn't a problem" and had appreciated this as they were not feeling “Too independent.”

People gave us mixed response about their involvement in care planning meetings. One person was very clear, saying “There are regular discussions on my care and any changes. You feel you can always tell someone and something will be done." One visitor said, "I'm very involved in the care planning". However, other people were not aware of decision making meetings about their care. For example, when professionals meet with the person to review their care.

Staff told us there was information about advocacy services available in the home. However, they said they did not have time to read this. Advocates act independently and support people to address or raise issues.

The registered manager told us about the needs of people who lived in the home. This included people with needs in relation to dementia, pressure sores and heart problems. People’s files recorded the support they received from other professionals. For example, nurses or staff in mental health teams. People told us they had no concerns about support from other professionals. They said, “If you need to see someone ask the nurse and she'll arrange it" and” I see the Chiropodist regularly, they come when I need them". However, one person said "On two occasions I asked to see the doctor but they didn't come. I did see the doctor yesterday when I asked though.”

Peoples’ conditions were monitored to help make sure their needs were met. For example, people’s positions were recorded when they were at risk of developing a pressure sore. Although we saw that one person’s weight was monitored, they had consistently lost weight and no referral to a dietician or GP had been made.

Another person had fallen a number of times over recent months but no referral had been made to the falls team or physiotherapist. This meant that people’s changing needs were not being responded to and met. We raised a concern about the lack of referrals and a request for a GP visit was made during the inspection.

People told us they were content with their meals. People were enthusiastic about the choice, quality and quantity of the food. People said, "They do exceedingly well with the food here, if you don't like what's on the menu they'll get you something else" and someone else said, "It's very good for a large place - good quality and you get enough to eat”.

People’s care files included details of their personal preferences, needs and support in relation to food and

Are services effective?

(for example, treatment is effective)

drink. We saw these were reviewed regularly to make sure staff offered the correct support. However, we observed that two members of staff were not aware of a persons' dietary needs and needed to be told this by other staff. We noted that people did not always have access to drinks and this had the potential for people to become dehydrated.

We also found support with meals varied in different areas of the home. We saw that in one area people required minimal support with eating their meal and interactions with staff were positive and relaxed.

In another area this was not the case. Staff were focused on tasks and they concentrated on handing out food to people. Staff did not wait for people to finish their meal or assist people appropriately. One person asked for help but no member of staff responded to this. Another person who had dementia became upset and their meal was taken away. One person rushed their food and staff did not try to encourage them to eat more slowly.

In another area people were offered a glass of wine with their meal. However, we saw that staff did not observe a tablecloth being removed and a glass shattered on the floor. One person lifted the dining table and staff were slow to respond to this. This did not reflect good support to make sure people's nutritional needs were met.

Are services caring?

Our findings

Most people who lived in the home had needs in relation to a dementia type condition. Due to this we used the Short Observational Framework for Inspectors (SOFI) observational tool. We also spent time with people and observed their daily life and the support they received.

We observed times when staff were respectful and kind to people. Staff helped people and offered them choices. Staff were caring with people and people spoke positively about staff. They commented, “It's like chatting to a friend", "They're all lovely people” and “They're very pleasant indeed." One visitor told us that they did not always feel staff attitude was as caring as could be expected.

Some people’s care files included information about their life history and previous lifestyle. This included details of their career, family relationships and previous hobbies or interests. It would be used by staff as a talking point to help build a relationship with the person they supported. However, we noted that there were gaps in this information in some files so staff had less knowledge about the person to help them build relationships.

People’s appearances reflected that their personal care needs had been met. The majority of people were well groomed and dressed appropriately. However, we did observe one person with trousers which were too tight and uncomfortable. This prevented them from sitting comfortably when they ate their meal. Another person’s clothes fell off their shoulders. Staff replaced this but the garment was too big. Wearing ill-fitting clothes did not protect peoples’ dignity. However, we saw that staff knocked on people’s doors before they entered the room and that support with personal care was undertaken discreetly. It was clear there was inconsistency in staff’s understanding in relation to dignity and the level of support people would receive.

The registered manager told us about support for people required with end of life care. People’s choices were recorded in their files and this included the medical treatments or interventions which were appropriate to the individual. For most people there were also records of how the person had been consulted regarding their wishes at the end of their life. However, for one person the form did not record if their next of kin had been consulted or whether the person wished for them to be consulted. One person suffered with cancer and professional support had been sought from MacMillan nurses to ensure that their needs were met.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Most people who lived in the home were confident that staff would listen to them and act on what was said. One person commented "I feel very confident that they do what I need them to do for me because they listen to you"; another said "By the way they run this home you can tell they listen to people." However, two people told us "It's too difficult to say if they listen to you because there is frustration on all sides."; "I am very reliant on the staff and I don't always get what I ask for."

Some people's concerns were addressed and records of this were kept. People told us about concerns; one person said, "I don't have any concerns at the moment but if I did I'd feel able to raise it with someone, I don't know who though." Another said "Yes, you can raise it with anyone and it gets sorted." However, one person said "I rang my bell and no one came so I thought I'd ring the office to complain. I didn't know the number so I rang the home I'd been in before to ask them to get me the number of the office here but the man there who I know very well said "leave it to me" and he sorted it out for me." The same person said "I know there is a complaint procedure". One visitor said "I feel very able to raise issues but don't see much in the way of corresponding outcomes".

People's capacity to make decisions was recorded and when necessary best interest meetings had been organised. Best interest meetings are held when a person is no longer able to make a complex decision for themselves. The meeting consists of people involved in the person's life and could include health care professionals and the person's representative. They assist the person to make a decision in their best interests.

People's needs, likes and choices were assessed to help make sure these were known when planning individualised care. People's assessment information included their likes and dislikes about leisure time. This included whether they preferred group or individual activity. This information was designed to help the home organise and plan activities. However, we found the amount of activities on offer varied across the home.

One person who lived in the home told us "If you want to join in something you can. I've done Scrabble and an exercise class, but if you want to be alone then you can."

People were assisted to one of the lounges to play Bingo, this did not take place and no alternative was offered. We observed some people were busy with pastimes in their own rooms; this included reading crosswords. Other people remained in their room but were not taking part in activities, and there appeared little opportunity for them to meet up with others who lived in the home. For other people who lived in one area of the home no activities took place.

People received visitors to the home throughout the day of our visit. This helped them maintain relationships with friends and relatives. We observed that staff chatted with people, discussed events and read one person's letter to them. This helped the person maintain this contact.

Are services well-led?

Our findings

We observed the registered manager was approachable throughout the visit. They interacted with staff and people who lived in the home. They offered support and guidance, reflecting a positive culture. Although this was a large home the registered manager was knowledgeable about the people who lived there. They were able to discuss each person's individual needs and how these were supported. This included the use of external professionals.

The registered manager told us about the service development plans for the coming year. These included staff development and training. There was a quality assurance system in place which was a planned programme of audits over the year; other managers visited the home to undertake some of these audits. Additionally, there was a review of falls and medication errors. These checks were planned to help make sure that the management of the home were aware of any areas of development or improvement. However, these audits had not identified some shortfalls, such as gaps in record keeping and inconsistencies in staff practice.

We found that accidents and incidents were reviewed to help make sure that any patterns or causes were identified and actions could be taken to prevent re-occurrence and help keep people safe.

People who lived in the home and their relatives were consulted through monthly meetings. This updated people about changes within the home and provided an opportunity for people to express their views. The registered manager had provided a notice board with information specific to dementia care for relatives to read. The responses to this had been positive and relatives had decided to establish their own support group in relation to dementia care. Staff meetings were also held, to keep staff up to date about practice.

People who lived in the home could not recall being asked about their care or completing a questionnaire. One person said "But they know, because I'd be telling them if I wasn't happy." However, we saw a management report which recorded the outcome of questionnaires. These had been completed by people who lived in the home and offered an opportunity for them to be consulted.

Staffing levels were based on current occupancy levels and the individual needs of the people residing in each of the units of the home. This allowed for continuity of care in each unit and the building of relationships between people who lived at the home, relatives and staff.