Four Seasons 2000 Limited

Bishopsmead Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 15 March 2017 and was unannounced. Since the previous inspection conducted in July 2016 the registration status of the service has changed to a new legal entity, but has remained with the same provider organisation.

Bishopsmead Lodge is registered to provide accommodation for persons who require personal or nursing care for up to 51 people. The service cares for older people, some of whom are living with dementia. At the time of our inspection there were 42 people living in the service.

There was a registered manager in place on the day of our inspection. 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.

In the main care plans contained risk assessments for areas such as falls, moving and handling and skin integrity and where risks had been identified the plans guided staff on how to reduce the risks. For example, plans contained hoist and sling details when required. Care plans did not reflect people's individualised needs. The quality and content of care plans were variable.

We found that arrangements in place for managing medicines were in the main managed safely. Some medicines were not stored correctly, in line with legal requirements. This was identified in a previous pharmacy check. Staff told us they were in the process of obtaining a new store cupboard for these medicines.

People's rights were in the main being upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. In people's support plans we saw information about their mental capacity and Deprivation of Liberty Safeguards (DoLS) being applied for. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely.

Records showed that a range of checks had been carried out on staff to determine their suitability for work. Staff were supported through an adequate training programme but further work was required regarding holding regular supervision. Supervision is where staff meet one to one with their line manager.

The staff we spoke with had a good awareness and understood their responsibilities with regard to safeguarding people from abuse. Staffing rotas viewed demonstrated that staffing levels were maintained in accordance with the assessed dependency needs of the people who used the service.

We observed some positive interactions between people and staff throughout the inspection. There was

plenty of laughter and the atmosphere was calm and friendly. Staff were knowledgeable about people's needs and were aware of their life histories and background. Staff told us how people preferred to be cared for and demonstrated they understood the people they cared for.

People spoke positively about the activities offered and told us the programme was varied and enjoyable. Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

People had access to on-going healthcare services. Records showed that people were reviewed by their GP, the physiotherapist, the tissue viability nurse, the chiropodist and the dementia well-being team.

Although regular staff meetings were not held staff felt well supported by the registered manager.

People advised that they would be either extremely likely or likely to recommend the service to friends and family if they needed similar care or treatment. They felt listened to and staff treated them with respect.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks were not consistently managed effectively in accordance with the person's needs.

Medicines were in the main managed safely.

Safe recruitment processes were in place that safeguarded people living in the home.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not consistently supported through a supervision programme.

People's rights were in the main being upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves.

People had access to on-going healthcare services.

Is the service caring?

Good

The service was caring.

We observed positive interactions between people and staff throughout the inspection.

Staff were knowledgeable about people's needs and were aware of their life histories and background.

People's care plans for end of life care needs and preferences required further development.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not reflect people's individualised needs. The quality and content of care plans were variable.

People spoke positively about the activities offered.

The provider had systems in place to receive and monitor any complaints that were made.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service has failed to fully meet the regulations.

Staff felt well supported by the registered manager.

People were encouraged to provide feedback on their experience of the service.

Bishopsmead 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 15 March 2017 was unannounced. The inspection was undertaken by two inspectors, a pharmacist inspector and an 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.

We reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

We spoke with 12 people, three relatives and eight members of staff. We also spoke to the registered manager and the regional manager.

We observed staff carrying out administering medicines to people during the morning. We reviewed the care plans and associated records of seven people who used the service. We looked at all the medicine administration records (MARs) in current use, two people's care topical application records and eight people's care records in relation to medicines. We also reviewed documents in relation to the quality and safety of the service, staff recruitment, training and supervision.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in July 2016 we found that arrangements in place for managing medicines were not safe. During this inspection we found that improvements had been made. However, some areas of their work required further development.

At the last inspection, we found some people's medicines were unavailable. During this inspection, staff told us they had made improvements to their ordering system. People's medicines were available for them. Staff recorded the medicines received and the amounts carried forward from one month to the next. This meant they were able to check the stocks and make sure people had received their medicines as recorded.

We saw staff on each floor give some people their morning medicines using a safe method. However the nurse working on the first floor was from an agency and had not worked at the home before. This meant they took longer giving the medicines. Some people did not receive their morning medicines until 12:00. Some people were prescribed medicines early in the morning, the night staff gave these medicines so people received them at the correct time.

The pharmacy provided monthly medicines administration records (MARs) for staff to complete when they gave people their medicines. A second member of staff signed and checked handwritten additions to the MARs, to reduce the risk of mistakes. Staff recorded when people had taken their medicines and the reason if a regular medicine was not taken.

Some creams and ointments were stored in people's rooms and applied by care staff when they provided personal care. Staff recorded this on separate charts kept in people's rooms. These included body maps to show where creams should be applied. One member of staff was taking a lead in this area by providing training, to make sure staff applied people's creams and ointments appropriately and kept accurate records.

We saw one example where a person often declined to have the evening dose of an eye drop, used to treat an eye condition. Staff told us they had not discussed this with the person's doctor to make sure it would not cause them harm. Another person was prescribed medicines for a number of different medical conditions, but often declined to take any of their medicines. This meant they would not have effective treatment. Staff told us the doctor had spoken with the person concerned and advised them of the importance of taking their medicines.

Medicines were stored securely. Staff checked and recorded the temperature of medicines storage areas to make sure they were safe for storing medicines. Arrangements were in place for medicines needing additional security. Staff kept suitable records of these medicines. However some of these medicines were not stored correctly, in line with legal requirements. This was identified in a previous pharmacy check. Staff told us they were in the process of obtaining a new store cupboard for these medicines.

Staff made regular daily, weekly and monthly checks of different aspects of the medicines handling in the

home. This helped to make sure that people's medicines were looked after safely. We saw six examples of daily medicines audits and six of weekly medicines audits. Each looked at one person's medicines for that day or week. We also saw a recent monthly medicines audit by the home manager. A plan was in place to address the issues raised in this audit.

Some people were prescribed medicines to be given 'when required'. Most people had protocols and record sheets in place to give staff additional information to help them give, and record, these medicines in a safe and consistent way. However, we saw four examples where these protocols were not in place for medicines. In addition two people were prescribed medicines 'when required' for 'end of life' treatment. There was information on the community prescription sheet about the dose of these medicines but there no protocols in place for staff to follow. This did not follow the home's medicines policy. Staff had not identified this in the various audits.

All of the care plans contained risk assessments for areas such as falls, moving and handling and skin integrity and where risks had been identified, the plans guided staff on how to reduce the risks. For example, plans contained hoist and sling details when required. We did note one exception where the person's risks had not been adequately assessed. It had been documented in the plan that the person had full mental capacity and often refused to have their position changed regularly, despite being classed as a very high risk of skin breakdown. Although staff were aware of the potential for refusal and had documented when the person refused, the guidance was "if refuses, walk away and come back in 15 minutes and explain what the effect of not being turned could do to her skin". However, there was no clear guidance on what staff should say or how they should explain the risks. This meant that it was not clear if the person was being provided with enough information to make an informed choice. It had also been documented that the same person often refused their medicines and again there was nothing documented that showed if staff had explained to the person how the risks of refusing might adversely affect their health. We recommend that the provider review the risk assessment staff guidance for supporting people to make informed decisions.

People were cared for in safe and clean environment. The laundry room has recently been refurbished. There are clear segregation procedures for clean and dirty laundry. We observed staff wearing the appropriate personal protective clothing when required. The domestic team took great pride in their work and people's rooms were cleaned daily. On the day of our inspection staff were steam cleaning the communal area. The registered manager told us that they intend to appoint an infection control lead. Regular infection control audits were conducted and identified actions were taken forward, such as the need not to use bathrooms as storage areas.

Appropriate arrangements were in the main in place for reporting and reviewing accidents and incidents. This included auditing all incidents to identify any particular trend or lessons to be learned. Accident and incident forms clearly identified the nature of the incident, immediate actions taken and whether any further actions were required. We did note one exception. This related to one person who had been found on the floor on 10 March 2017. The investigation outcome stated "requires hoist at all times", however the person's care plan had not been updated and still guided staff that the person was "able to mobilise using a Zimmer."

Records showed that a range of checks had been carried out on staff to determine their suitability for work. This included obtaining references and undertaking a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal background and whether they were barred from working with vulnerable adults.

The staff we spoke with had a good awareness and understood their responsibilities with regard to

safeguarding people from abuse. They were able to explain the actions they would take if they suspected a person was being abused. Staff also understood the term 'whistleblowing'. This is a process for staff to raise concerns about potential malpractice at work.

Staffing rotas viewed demonstrated that staffing levels were maintained in accordance with the assessed dependency needs of the people who used the service. When required the service used agency staff. One member of staff told us: "Staffing levels are ok at the moment."

People told us they felt safe. Comments included; "They [the staff] look after you, there are people around at night"; "You feel someone is always around"; "Yes I feel safe"; and "I am safe; I got this" whilst pointing to their alarm.

Requires Improvement

Is the service effective?

Our findings

People's rights were in the main being upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. In people's support plans we saw information about their mental capacity and Deprivation of Liberty Safeguards (DoLS) being applied for. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely.

Staff understood the principles of the mental capacity act and understood the need to gain people's consent before supporting them. One member of staff said "I always talk to people, make eye contact, and tell them what I'm doing. If they refuse I would go back a bit later."

There were areas of their work regarding consent which required further development. Some people had bed rails in situ. Although plans contained bed rails consent forms, these had not always been completed correctly. For example, we looked at two bed rails consent forms which had been completed in conjunction with people's relatives. However, the forms had not been completed fully; the section in relation to whether the person would prefer or not prefer to have bed rails in place, had not been completed. This meant that the forms did not clearly document the decision making process. The registered manager advised that they would review their paperwork and ensure that the consent forms were completed correctly.

One person had a "Do not resuscitate" form in their care plan which indicated the person had been involved in the decision making process. However, it had recently been documented in the plan that the person had since changed their mind and now did want to be resuscitated. It had been documented on 9 March 2017 "GP visit booked to discuss DNAR because [person's name] doesn't want this in place", but the form was still in place. One member of staff told us; "The form needs reviewing urgently" and they agreed to take this matter forward.

People were assessed for the risks of malnutrition and dehydration. People's weights were monitored and when weight loss was noted, advice and support was sought accordingly. For example, one person had been assessed as at risk of choking and a referral had been made to the Speech and Language therapist (SALT). The care plan contained details of their recommendations, which included the required texture that food should be served at and the position which the person should be in when being assisted to eat. We saw this person being assisted with their lunch and saw that the guidance within the plan was being followed.

Some people were having their food and fluid intake monitored. All of the food and fluid charts had been completed in full, including details of when people had been offered but refused drinks or food. One person who had been losing weight was having their food intake monitored. The charts showed that the person often didn't eat all that they were given. We asked them if they didn't like the food that was on offer, and they said "I just don't always fancy it, but they will always get me something different if I ask for it. They always give me the choice to have something else."

We observed that people had access to drinks all day in the communal areas and drinks were within reach for people in their rooms. The chef prepared food at the correct consistency, in accordance with people's needs. They also demonstrated an understanding of peoples' specific dietary requirements and people's food preferences and dislikes were highlighted on the kitchen's whiteboard. In the main we received positive comments about the food. They included; "The cooked breakfast this morning was perfect"; "I eat what they bring, they bring me lovely meals"; "They come and ask you what you want and bring it"; and "The food is alright. There is plenty of drink and occasionally biscuits. I like the juice. The water is terrible."

Staff were not consistently supported through a regular supervision programme. Supervision is where staff meet one to one with their line manager. We reviewed staff records which demonstrated that regular staff supervision had not been conducted. This meant that staff had not received effective support on an on-going basis and development needs were potentially not acted on. However, the registered manager was aware of this and had in part taken steps to address this position. They had introduced a supervision matrix which tracked the supervisions conducted. Staff who had the responsibility of conducting supervision were reminded by the registered manager of their responsibilities and the need to comply with the provider's supervision policy.

Staff were supported through an effective training programme. The overall compliance rate for mandatory modules currently stood at 91%. This included modules such as basic life support, fire safety, moving and handling and infection control. Staff told us they felt well supported by their training to enable them to carry out their duties effectively. They confirmed they had access to face to face and e-learning training. The registered manager told us about the service's practical training programme. Subjects include; wound management, person-centred care planning and dysphagia training.

People had access to on-going healthcare services. Records showed that people were reviewed by their GP, the physiotherapist, the tissue viability nurse, the chiropodist and the dementia well-being team.

Good

Is the service caring?

Our findings

We observed some positive interactions between people and staff throughout the inspection. There was plenty of laughter and the atmosphere was calm and friendly. Staff spoke positively about their job. Comments included "The most important thing about this job is to know people's needs", "I've always been a caring person and always wanted to do this job" and " I would 100% recommend it here, the staff in here are good, the best."

We observed one person eating their lunch in the dining room. They were eating their dessert and had left some. A member of staff asked if there was anything wrong with it, and the person explained that it was very nice but the portion was a bit big. The staff member relayed this message to the chef. The chef told the person "Don't worry, leave what you can't manage and I'll make sure to give you a smaller portion tomorrow."

Staff were knowledgeable about people's needs and were aware of their life histories and background. Staff told us how people preferred to be cared for and demonstrated they understood the people they cared for. One member of staff told us; "We get to know the individuals and follow their care plan. We ask their relatives about their likes and dislikes and find out their preferred routines. [Person's name] every other day has a full body wash. She lets you know what she wants and is directive with her creams. She likes her food piping hot and is quite fussy. The chef comes to see her and the vegetables have to be cooked properly. She's a lady and knows what she wants. It's nice when they get to know you." Another member of staff told us: "[Person's name] used to be a scullery maid. She likes to get up at a certain time. She likes her cutlery to be placed in a certain way. There has to be a certain number of tissues on top of their glasses case. She likes routine and has her own chair. She'll re-arrange things in a certain way."

Staff enabled people's independence as far as possible. One person told us; "Staff help me with personal care. I have a shower and they wash my hair. I have a strip-down wash every morning which I can do myself. I shave myself. The staff are alright. I get up and go to bed when I want to. I get help when I need it." One person provided negative feedback regarding their personal care and told us they had been criticised by staff for wetting the bed.

One person was celebrating their birthday. They had a 'Happy Birthday' banner on their bedroom door and the kitchen staff were baking them a cake.

One relative praised the level of care of the service. They told us; "Bishopsmead is brilliant. Your family is looked after. [Person's name] is really happy here. I'm welcomed here at any time. I bring in my dog. I would have anyone to come here. I visit regularly, every four weeks. It's quite a long way but I wouldn't move him [their relative]. The staff are amazing and the [registered manager's name] is unreal."

Requires Improvement

Is the service responsive?

Our findings

Care plans did not reflect people's individualised needs. The quality and content of care plans were variable. In one person's care plan it had been documented in the medication section that the person had diabetes and that it was 'not well controlled and hasn't been for a long time.' Despite this, there was no reference within the plan to how staff should care for someone with diabetes. The nutrition plan was incorrect, because it had been documented in the dietary requirements section 'N/A' and it should have made reference to an adjusted diet. When we reviewed the food charts for this person, records showed the person had been eating jam sandwiches, cake, biscuits and ice cream. When we queried this person's care with two members of staff, neither were aware that the person was diabetic. The service had not fully considered the person's specialised diet.

In two of the plans we looked at, there was documentation in relation to people's behaviour that staff or other people might find upsetting or distressing, but there was no guidance for staff on how to deal with this. For example, in one person's plan staff had documented that the person had called the staff names and accused them of hitting the person, but there was no guidance for staff on how they should respond to this, or how to deal with such accusations. In another person's plan it had been documented that they could get "anxious and depressed". There was nothing to inform staff how to effectively support this person. The only guidance documented was that the person had been prescribed medication for anxiety.

We saw that one person had attended an appointment the day before where a health professional had identified a pressure sore behind the person's ear. A letter had been written to staff asking them to dress the sore and ensure the person's hearing aid did not cause undue pressure. However, there was nothing within the care plan to indicate that staff had noticed the person had a sore ear, despite the plan guiding staff to apply the person's face cream daily and to ensure the person had their hearing aids in each morning. In addition, the plan had not been updated to reflect the findings of the health professional.

One person was having oxygen therapy 24 hours a day; however, there was limited guidance for staff within the plan to detail how staff should manage this. The plan stated "2 litres of oxygen at all times. Keep nasal tubes clean", but there was nothing about how to maintain the equipment, how to use it safely or the cleaning schedule for the equipment. In addition, there was no warning notice on the person's door to highlight to staff and visitors that oxygen was in use. The warning notice acts as a powerful deterrent and reminder to extinguish any ignition sources before entering areas containing oxygen.

Although there were sections in people's care plans for end of life care needs and preferences to be recorded these were inconsistently completed and contained minimal information. We saw one plan that detailed the person's religious beliefs, who they wanted to be contacted and whether they wanted to be hospitalised. However, there were details in another person's plan that showed they had been reviewed by their GP following a chest infection. The advice from the GP was for staff to have a discussion with the person about advanced treatment in relation to future chest infections as they were likely to recur. This was dated 30 January 2017, but there was nothing documented to indicate that this discussion had taken place. In other end of life care plans we looked at the only thing documented was "DNR (Do Not Resuscitate) in

place".

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Wound care plans were clear and detailed. There were photographs in place which showed stages of wound healing. Advice had been sought from the tissue viability nurse. The care plan for one person who had been admitted with pressure sores detailed how staff should support the person to prevent any deterioration, including the use of an air mattress. We saw that where other people had air mattresses in place, there were charts for staff to sign daily to check they were at the correct setting, but there was no chart in place for this person. The last recorded weight for the person was 49.6kgs, but when we checked the air mattress it was set for a weight of 130kgs. This meant the mattress was incorrect and that as well as being uncomfortable for the person could cause further wound deterioration. When we pointed this out to a staff member the mattress was set to the correct weight and a mattress monitoring chart was put in place. All of the other air mattresses that we looked at were set correctly.

Care plans were in the main written in conjunction with people or their representative. With two exceptions people had knowledge of their care plan. Life history documents were all completed in full and showed that time had been spent talking with people about their preferences and their life histories.

People spoke positively about the activities offered and told us the programme was varied and enjoyable. Activities included music and movement, skittles, gardening, bingo, board games, arts and crafts. An outside entertainer visits once a month. People have also making bunting for a local charity. A retired vicar visits once a week. People were encouraged to join in activities. For those who chose to remain in their rooms the activities coordinator spent time one-to-one time with them. The activities coordinator was enthusiastic about their role and told us about their intended plan to hire a mini-bus to take people out for a picnic in the park.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

The provider had systems in place to receive and monitor any complaints that were made. We reviewed the complaints file. Since July 2016 three complaints had been received. Where issues of concern were identified they were taken forward and actioned. People and their relatives told us they knew how to make a complaint.

Requires Improvement

Is the service well-led?

Our findings

The service has failed to fully meet the regulations and some areas of their work required further development. Examples of this related to risk management, person-centred planning, regular supervision, end of life care plans and bed rail assessments. The impact of these failings meant that there was a potential that people were not receiving the appropriate care and treatment specific to their needs. Staff should receive appropriate on-going or periodic supervision in their role to make sure competence is maintained. In the main the issues that required further work had also been identified though their internal auditing processes and was recognised by the registered manager as work in progress.

Although regular staff meetings were not held staff felt well supported by the registered manager. Comments included; "I feel really well supported. Everybody's got a small part to play in a big wheel, but if one part breaks the other part helps with the repair"; "We share ideas for improvement"; "I have enough training and we're supported by the senior staff. [Registered manager's name] is really supportive and encourages us to do better. She always says thank you which means a lot." Staff said they last attended a staff meeting "a couple of months ago." They said they were aware of action plans to improve the service and that action plans were put up for all staff to see. They said "we all contribute." One said "there's been a huge improvement since last year."

A new regional manager has recently been appointed. They visit the service regularly and compile a visit report regarding the areas of work they have reviewed. These include issues such as care documentation, consent and choice, communication with external professionals and staffing. The visits were used as an opportunity for the regional manager and registered manager to discuss issues related to the quality of the service and welfare of people that used the service. Clear action plans were evident, such as the need to up-date pain and bedrail assessments.

Regular resident meetings were not held . Regular meetings encourage individual and group feedback about the quality of care. Formal feedback was sought from people through questionnaires. From 2 February to 11 March 2017 six people provided their feedback on the level of service provided. They all advised that they would be either extremely likely or likely to recommend to the service to friends and family if they needed similar care or treatment. They felt listened to and staff treated them with respect. Comments from the questionnaires included; "I like the care I receive here and all the staff are great"; "I think this is the best home I've been in"; "Yes it's always happy. I would like to spend time with the care assistants but that's not always possible as there are other people to look after as well as me. They do a great job." Following mixed comments from people regarding the food the registered manager has implemented an action plan to take their concerns forward. This has included further training for the chef, the need to improve communication between the care staff and the chef and to present menus to people.

To ensure the safety of the service health and safety checks were conducted, such as checks on equipment and standard of electrical, gas and water safety had been completed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We 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 Care plans did not reflect people's individualised care and treatment needs.