Hartford Care (South West) Limited

Bethel House

Inspection report

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Date of inspection visit:
07 June 2016
08 June 2016
09 June 2016

Date of publication:
28 June 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on the 7, 8 and 9 June 2016 and was unannounced.

Bethel House is registered to provide accommodation and personal care for up to 31 people. The service does not provide nursing care. At the time of our inspection 29 people were living at the home. The home provides a service for older people and people living with dementia. Accommodation at the home is provided over two floors, which can be accessed using stairs or passenger lifts. There are large garden and patio area's which provide a safe and secure private leisure area for people living at the home.

The service had a registered manager. 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.

People told us they were safe and well cared for at the home. Staff knew how to identify abuse and protect people from it.

People knew how they could raise a concern about their safety or the quality of the service they received.

The service had carried out risk assessments to ensure that they protected people from harm.

There were enough staff deployed to provide the support people needed. People received care from staff that they knew and who knew how they wanted to be supported.

Medicines were ordered, stored, administered and disposed of safely.

Staff had developed caring relationships with people who used the service. People were included in decisions about their care.

People who required support to eat or drink received this in a patient and kind way.

The registered manager was knowledgeable about The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The Metal Capacity Act Code of Practice was followed when people were not able to make important decisions themselves. The manager understood their responsibility to ensure people's rights were protected.

People and relatives were asked for their views on the service and their comments were acted on. There was no restriction on when people could visit the home. People were able to see their friends and families when they wanted.

We have made a recommendation about how the provider can reduce the risk of social isolation. You will find this in the responsive section 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?

Good

The service was safe. People told us that they felt safe and well looked after.

Staffing levels were organised according to people's needs and the provider followed an appropriate recruitment process to employ suitable staff.

People received their medicines as prescribed and medicines were stored and managed safely.

Is the service effective?

Good

The service was effective. Staff were provided with training and support that gave them the skills to care for people effectively.

People's rights were protected because staff were aware of their responsibilities under the Mental Capacity Act 2005.

People had access to and were supported with their healthcare needs, including receiving attention from GPs and routine healthcare checks.

Is the service caring?

Good

The service was caring. People were comfortable and relaxed in the company of the staff supporting them.

Staff treated people with dignity, respect and kindness. They knew people's needs, likes, interests and preferences.

People were involved in making decisions about their care, treatment and support as far as possible.

Is the service responsive?

Good

The service was responsive. People using the service had personalised care plans and their needs were regularly reviewed to make sure they received the right care and support.

Staff responded promptly to people's changed needs or circumstances and relevant professionals were involved where

needed.

People were supported to maintain relationships with their friends and relatives.

Is the service well-led?

Good

The service was well-led. People spoke positively about the registered manager and how the service was run.

People were asked for their views of the home and their comments were acted on.

Systems were in place to monitor the quality and safety of the service.

Bethel House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 7, 8 and 9 June 2016 and was unannounced. The inspection was carried out by one inspector.

Before our inspection we reviewed information we held about the service. We checked to see what notifications had been received from the provider. A notification is information about important events which the provider is required to tell us about by law. We did not ask the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with the registered manager, deputy manager, three members of the care team, the chef, six people living at the home, three relatives and two visiting healthcare professionals. Following our inspection we spoke with a community psychiatric nurse and a general practitioner (GP).

We looked at the provider's records. These included four people's care records, four staff files, a sample of audits, satisfaction surveys, staff attendance rosters, policies and procedures.

We pathway tracked two people using the service. This is when we follow a person's experience through the service and get their views on the care they received.

Some people were not able to verbally communicate their views with us or answer our direct questions. 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.

Good

Is the service safe?

Our findings

People told us they felt safe living at Bethel House. One person told us, "Yes I feel safe, no worries at all". Another person told us, "I feel safe here, and someone will always come and see me, night and day". A relative told us, "I have no doubt in my mind that X [person] is very safe here. The staff are very aware that they are not good on their feet and are always there to support them". A GP told us, "I am more confident in the safety of people since the new manager took over last year. She is very good at ensuring peoples safety".

People were supported to take positive risks to enhance their independence, whilst staff took action to protect them from avoidable harm. Where risks were identified, there was guidance for staff on the ways to keep people safe in the home and in the local community. Staff gave examples of this such as checking the environment for trip hazards and supporting people with mobility needs to access the gardens. One person told us, "Staff help me when I want to go for a walk in the garden. They make sure I am safe and come with me if I want them to". Individual risk assessments were personalised, current and regularly reviewed.

There were various health and safety checks carried out to make sure the building and systems within the home were maintained and serviced as required to make sure people were protected. These included regular checks of the environment, fire safety, gas and electric systems. At the time of our inspection the home was being refurbished with extensive building works in progress. The registered manager and provider met regularly with the building contractors to look at any risk associated with the ongoing works. Risk assessments were reviewed and updated accordingly to keep both people and visitors to the home safe.

Equipment used to support people with their mobility needs, including hoists, had been serviced to ensure it was safe to use and fit for purpose. Staff had received training in moving and handling, including using equipment to assist people to mobilise. One staff member said, "It's really important we know how to help people mobilise safely. We have to ensure their safety at all times so our training in this area is important. It's also important to know peoples limits on what they can and can't do for themselves. We get that information from care plans and at handover".

Staff were aware of how to recognise and protect people from abuse. The home responded to safeguarding concerns and worked with the local authority. They obtained advice from them when appropriate and the registered manager reported safeguarding issues accordingly. Staff had received safeguarding training. One staff member said, "I've never seen any form of abuse but I know that if I saw it I would report it. It's my duty of care to ensure people are protected". Staff were aware of the procedures in place to keep people safe and the levels of concern they needed to report.

Safe recruitment processes were in place. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Application forms had been completed and recorded the applicant's employment history, the names of two employment referees and any relevant training. There was also a statement that confirmed the person did not have any criminal convictions that might make them unsuitable for the post. We saw a Disclosure and Barring Service (DBS) check had been obtained before people commenced work at the home. The Disclosure and Barring

Service carry out checks on individuals who intend to work with children and adults, to help employers make safer recruitment decisions.

There were enough skilled staff deployed to support people and meet their needs. During the day we observed staff providing care and one-to-one support at different times. Staff were not rushed when providing people's personal care and other care needs and their planned daily activities were attended to in a timely manner. Staff told us there were enough of them to meet people's needs. We observed staff providing care in a timely manner to people throughout our inspection. Staff responded to call bells quickly. People said call bells were answered promptly and staff responded quickly when they rang for help.

There was a clear medication policy and procedure in place to support staff to manage people's medicines safely. Staff designated to administer medicines had completed a safe handling of medicines course. This had included a practical assessment to ensure they were competent at this task. Medicine administration records (MAR's) included an up to date list of identified allergies. MAR's had been completed to indicate when medicines had been given or had been refused. Medicines that were required to be kept cool were stored in an appropriate locked refrigerator and temperatures were monitored and recorded daily. Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD's). The CD's in the service were stored securely and records were accurately maintained.

During our inspection we found that the home was clean and free from odours. This helped to ensure people's dignity. We found that the home had effective systems in place to ensure that the home maintained good hygienic levels and that the risk of infection was minimised.

The provider had plans in place to deal with foreseeable emergencies in the home. Emergency plans were in place for staff to follow. For example, in the event of a fire. Evacuation sledges were located and readily accessible on stairways and people living at the home had a Personal Emergency Evacuation Plan (PEEP). The provider had a reciprocal agreement with a nearby care home to relocate people to a place of safety if evacuation of the home was necessary.

Good

Is the service effective?

Our findings

People and relatives told us they were involved in decisions about their care and treatment. Their consent had been discussed and agreed in a range of areas including receiving medicines and support. Staff were knowledgeable about the importance of obtaining people's consent regarding their care and treatment in other areas of their lives. One person told us, "The staff are very good at letting me do what I want to do but they always ask me politely if they can help in any way. Sometimes if I'm feeling fragile they do help me". Another person said, "They always knock my door before coming into my room. They don't have to and I've told them so but they still do it". A relative told us, "X [relative] can't make decisions about their care so I do it with them because I have Power of Attorney (PoA). The home asked me for a copy of this before they moved in. The manager and staff involve me in all aspects of my relatives care". A PoA is a written document that gives someone else legal authority to make decisions on another person's behalf. Copies of those documents where relevant were kept securely in the registered manager's office.

For people living with dementia or for people with communication difficulties the provider used the 'Abbey Pain Scale' for the assessment of pain in people. The pain scale is an instrument designed to assist in the assessment of pain in people who are unable to clearly articulate their needs. For example by observing changes in facial expression, behavioural changes and psychological changes. Building pain assessment into existing care plans means it will become familiar to staff and essential when pain occurs. By using this method to assess pain on a regular basis, pain is more likely to be detected and acted upon. For people who experienced pain their needs could be met in a proactive way and ensured as far as was possible that pain and discomfort was reduced and increased their wellbeing.

People were supported by staff with appropriate skills and experience. Staff told us they had the training they needed to care for people and meet their assessed needs. There was an up to date training and development plan for the staff team which enabled the registered manager to monitor training provision and identify any gaps. This helped ensure that staff kept their knowledge and skills up to date and at the required frequency. Staff shared examples of recent training courses such as safeguarding of people at risk and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). One member of staff told us, "Yes the training is good here. We get the training we need to support people well".

New staff had undergone an induction which included the standards set out in the Care Certificate. The Care Certificate replaced the Common Induction Standards and National Minimum Training Standards in April 2015. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Training included for example, moving and handling, infection control, food hygiene, medicines management, dementia awareness, safeguarding of adults at risk and the Mental Capacity Act 2005 (MCA 2005).

Staff told us supervisions took place every four to six weeks and we saw records to support this. Supervision and appraisal are processes which offer support, assurances and learning to help staff development. Staff received regular one to one supervision, annual appraisal and on-going support from the registered manager. This provided staff with the opportunity to discuss their responsibilities and the care of people

living at the home. Records of supervisions detailed discussions and there were plans in place to schedule appointments for the supervision meetings. Staff had annual appraisals of their work performance and a formal opportunity to review their training and development needs. Staff felt supported and able to discuss any important issues with the registered manager at any time. One member of staff told us, "I know that if I have any concerns about my work or anyone living here I can talk to X [registered manager] at any time".

People had been assessed as to the level of capacity they had to make certain decisions. When necessary the staff, in conjunction with relatives and health and social care professionals, used this information to ensure that decisions were made in people's best interests. For example, one person's medicine was given to them covertly because they did not understand the importance of it and had refused to take it. We reviewed the mental capacity assessment and best interest decision meeting notes that included the person, their relatives, the prescribing GP and other health care professionals. The service worked closely with professionals and relatives to ensure that people's rights were upheld.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection one person living at the home was subject to a DoLS. The home had submitted a number of applications to the local authority which had yet to be authorised. The registered manager knew when an application should be made and how to submit one. They were aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that any decisions are made in people's best interests. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

At lunchtime people received individual support in a discreet and patient manner. People could choose what they wanted to eat but staff told us people often changed their mind. At lunchtime staff presented two meals to each person and gave them a choice. If people did not want either they were offered alternatives such as omelettes. A member of staff told us, "If you ask people what they want they are often unsure. I think by actually offering people a meal and letting them see it works better for them. They get to see and smell the food and make a choice that way. They are more inclined to eat well this way". The deputy manager told us, "We prefer to let people see and smell a meal and make their own choice in that way".

People who required support to eat received this in a kind and patient way. People commented on the high quality of the meals and we saw that fresh vegetables, salad and fruit were readily available. One relative told us, "I often have a meal when I'm visiting. The food is very good and it's so nice to be able to enjoy that experience with X [relative]. We saw from the written records that when necessary the service regularly involved other health and social care professionals in people's dietary needs. This included GPs and other associated healthcare professionals. This supported people to maintain good health.

People were supported with their healthcare needs, including receiving attention from GPs and routine healthcare checks. A visiting GP told us they regularly visited the home and found the registered manager and staff to be very good at calling them in in a timely way. They also told us they had the utmost confidence

in the registered manager who had only been in the service for about one year and had seen a change for the better in the way care was delivered.

People's healthcare needs were considered within the care planning process. Assessments had been completed on people's physical health, medical histories and psychological wellbeing. Arrangements were in place for people's healthcare needs to be monitored through a regular review process. Care records demonstrated people had received visits from health care professionals, such as doctors, chiropodists and opticians.

People's rooms were decorated and furnished according to people's choices. There were items of personal value on display, such as photographs, memorabilia and other possessions that were important to individuals and represented their interests.

Good

Is the service caring?

Our findings

People told us said they liked the staff and described them as "kind", "friendly" and "helpful. People and relatives told us staff were caring and looked after them well. One person said, "Its lovely here, I am cared for very well. The girls [staff] are full of beans, always smiling and laughing with us. It really brightens up the day". Another said, "The staff are so nice to me, this is my home". A relative told us, "Bethel house is very homely. It's not too big and when I come to visit it is like a second home. The staff are so welcoming and even look after me when I'm here. They always make me tea and offer me a meal. Yes it is a lovely caring home". Relatives were able to visit the home without restrictions. One person told us their family member was always welcome at the home.
Staff cared for people in a relaxed, warm and friendly manner. We saw that non care staff who worked in the home such as kitchen staff and the handyman took time to sit with people and chat. Staff sat talking with people and engaged in lively conversations about their families, social events and sharing memories. There was a lot of laughter and we noted that staff took every opportunity to engage with as many people as possible. For example, by bending down to ask if a person would like more tea, by touching a person's hand to ask if they were ok, and by frequently popping in and out of bedrooms to check on people.

People's privacy was promoted and respected. A number of people told us they liked to spend time in their rooms but could choose to sit in the communal areas if they wished. People's bedroom doors were pulled shut unless the person expressed a preference to have the door open. Staff knocked bedroom doors and waited for permission before entering. People told us staff always did this and that they respected their privacy one person saying, "Staff never come in without knocking the door first".

People were supported to make decisions and choices. One person told us, "Staff ask what you want to do and I go to bed and get up when I want too. If I want to lay in on a Sunday morning I can. Nobody tells me what to do". Each person had a named keyworker staff and there were advocacy arrangements, as well as family input, to represent people's interests. A relative told us that they were consulted about their family members' care and felt fully involved.

People's care needs, choices and preferences were recorded and written in a person centred way. Information within care plans reflected what was important to the person now, and in the future. Staff were knowledgeable about the people they supported and were able to tell us about people's individual needs, preferences and interests. Their comments corresponded with what we saw in the care plans. Care plans were person centred and promoted people's involvement and understanding. Care plans gave detailed descriptions of their individual needs and how support was to be provided. There had been input from families, historical information, and contributions of the staff team who knew them well with the involvement of people themselves. People were supported to maintain relationships with their family and friends. Details of important people in each individual's life were recorded. A relative confirmed they were kept up to date and they were always welcomed in the home when they visited.

People were supported to express their views when they received care and staff gave people information and explanations they needed to make choices. One person told us, "It's all very good, I have freedom of

choice". Another person said, "The staff always have time for a chat. They are very accommodating and will listen to me. I'm treated very much as a person". Staff provided care to people in a kind, attentive and compassionate way. For example, staff talked people through the care and support they were to offer them before and during the process, offering good explanations and reassurances to people.

The service had received many compliments from relatives. For example, "We just wanted to let you know that all your hard work and kindness made a huge difference to all of us and we greatly appreciate all that that you did" "It is extremely well run, with carers that show real commitment and belief in what they do" The end of life care X [person] received was conducted in a professional, warm and caring manner, always respectful and helping them to retain their dignity" and "This is a lovely care home. It is warm, friendly and always clean and tidy. The staff are lovely which is the most important thing".

Good

Is the service responsive?

Our findings

People told us they received a personalised service that was responsive to their needs. Before people came to live at the service their needs were fully assessed. This was achieved through gathering information about the person's background and needs as well as meeting with family and other health and social care professionals to plan the transition appropriately. One relative told us, "The manager came to our home before X [person] came to live at Bethel House. They were very thorough and went through everything with us. They wanted to be sure they could do everything X needed and I suppose we wanted to make sure of that as well. It was very reassuring to know they wanted to know all about X first".

Health care professionals spoken with indicated the service was responsive to the needs of the people living at the home. One told us, "They ask for help and support and work with us to get the best approach for the person. They have adapted their work practice in response to people with dementia".

Care plans were person centred and contained guidance about people's personal preferences for how they liked to be supported. For example, one care plan explained how the person liked to be assisted in the community. Another care plan explained how to support a person who needed to be prompted with personal care. Care plans were detailed and explained the actions that were needed to meet people's needs. This was to ensure that people's full range of care needs were met at the times of peoples choosing. Bedrooms reflected people's personality, preference and taste. For example, some rooms contained articles of furniture from their own home and people were able to choose furnishings and bedding.

The provider took account of people's changing needs and their care and support needs were regularly reviewed. This was achieved through annual care reviews or more frequently where needs had changed. When this happened, people's records were updated appropriately. For example, where a person's mobility needs had changed following a fall we saw that risk assessments had been updated to reflect changes in how to support the person to mobilise safely. Review meetings involved the individual, relatives or other professionals involved in people's care. This process helped the registered manager and staff evaluate how people's needs were being met.

Corridors were spacious with good lighting which is crucial for aiding people living with dementia to make sense of their environment. Doors and surrounds leading to people's rooms were personalised with 'pictures' which provided memory stimulation and recognition of their room. The garden area was designed following the same principles and included with minimal door thresholds which made it easier for people to access the garden safely. Well maintained paths within the garden helped to minimise trip hazards. Seating provided resting points along the paths for people with limited mobility.

People and relatives said they would speak to the manager or their keyworker if they needed to complain about anything. One person told us staff chatted with them if they felt unhappy. The complaints procedure was displayed within the service and available in an easy read format to help people understand the information. When speaking with staff, they showed awareness of the complaints process and said they were confident to approach the manager. Records showed there had been no complaints about the service

since our last inspection. A relative told us they had raised an issue in the past but this had been dealt with immediately by the manager.

People told us there was an activity programme and this was on display in the entrance to the home but people and relatives told us this wasn't happening as much 'at the moment'. The registered manager told us the activity organiser had left the service three weeks before our inspection and they had yet to find a replacement. The activities on display covered the period 6-12 June 2016 and included, musical bingo, boards games, fun quiz and light exercise however during the two days we visited the home we did not see people engaged in meaningful and stimulating activities and did not see any activities taking place. We recommend the service seek to ensure people are not at risk from social isolation and recognise the importance of ensuring activities promote social contact and companionship during the interim period.

Good

Is the service well-led?

Our findings

People, relatives, staff, and healthcare professionals told us the home was well-led. One person told us, "She [registered manager] is so nice and approachable. I've seen a few managers here but she is the best of them all". A relative told us, "If you had come here a year ago I wouldn't have been able to be as positive or confident as I am today. X [registered manager] has been a 'breath of fresh air'. She really has worked hard to pull the service around. A visiting GP and healthcare professional gave us similar comments.

The home had a clear management structure in place led by an effective registered manager who understood the aims of the service. The registered manager was knowledgeable about the people in the service and spent time in all areas of the service daily and monitored staff and the delivery of care closely. Staff told us they felt part of a big team and worked well together in order to provide consistency for the people living at the home and felt very well supported by the registered manager. One member of staff said, "We all work together as a team". Staff told us the morale was excellent and that they were kept informed about matters that affected the service.

Staff we spoke with described how the registered manager constantly looked to improve the service. They discussed how they reflected on what went well and what did not and used this to make positive changes. Staff told us there was good communication within the team and they worked well together. Staff, people and relatives told us the registered manager was an extremely visible leader who created a warm, supportive and non-judgemental environment in which people had clearly thrived.

Staff said they would feel confident raising any concerns with the registered manager, deputy manager or senior staff. They also said they would feel comfortable raising concerns with outside agencies such as the Care Quality Commission (CQC), if they felt their concerns had been ignored. Comments from staff included "I would have no hesitation at all in reporting any issues of unsafe practice or abuse", and "How would you feel if it was your mum or dad? I would expect someone to protect my relatives, so yes I would do something about it. Most definitely". Staff also understood their right to share any concerns about the care at the service and were confident to report poor practice if they witnessed it using the provider's whistleblowing procedure.

There were systems in place to review the quality of service in the home. Monthly and weekly audits were carried out to monitor areas such as health and safety, care plans, accidents and incidents, and medication. Unannounced night visits by the registered manager were undertaken. The last night visit took place at 4am in May 2016 where no concerns were found. This looked at the security of the home, cleanliness, hourly checks maintained and documented, handover records and staff being in allocated work areas.

We looked at recent staff meeting minutes which were clear and focused on people's needs, the day-to-day running of the service and any planned improvements.

Residents / relatives meetings were held regularly to gather their feedback about the service. We looked at

the minutes of the last meeting in April 2016. One topic discussed was the refurbishment of the home that was due to start in May 2016. One person asked for the plans for the refurbishment to be made available. During our inspection we noted that the plans and architect drawings were displayed for people to see.

Incidents and accidents were reviewed to identify trends. Any outcomes were included in an action plan and reviewed regularly or if things changed. The service had notified us of any incidents that were required by law, such as the deaths, accidents or injuries. We were able to see, from people's records that actions were taken to learn from incidents. For example, when accidents had occurred the registered manager had reviewed risk assessments to reduce the risks of these happening again. The provider had also notified us in April 2016 that building works were due to commence in May 2016 and that disruption to the service was possible. They also advised the fire and rescue service, local authority and relatives and submitted an action plan / risk assessment. This helped to ensure that people were safe and protected as far as possible form the risk of harm.