Barchester Healthcare Homes Limited

Stamford Bridge Beaumont DCA

Inspection report

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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

This inspection took place on 29 February 2016 and was announced. The registered provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the location offices when we visited.

Stamford Bridge Beaumont DCA (Domiciliary Care Agency) provides personal care to people living in their own flats within an assisted living complex. The assisted living complex comprised of 30 one-bedroomed flats on the same site as a nursing home with which it shares some services. At the time of our inspection there were 24 people living in the flats, and five of these received personal care from the service.

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse. Staff we spoke with understood the different types of abuse that could occur and were able to explain what they would do if they had any concerns. We found that people's needs were assessed and risk assessments put in place to reduce risks and prevent avoidable harm. Most of these were reviewed regularly.

The registered provider had a safe system for recruiting staff and was taking appropriate steps to ensure the suitability of workers. There were sufficient staff to meet peoples' needs, including in the event of sickness and absences.

Where staff supported people using the service to take medication, we found that this was accurately recorded on Medication Administration Records. Staff had received training in administering medication and the registered provider completed audits of medication records and practice. This showed that there were systems in place to ensure people received their medication safely.

Staff completed a range of training to help them carry out their roles effectively and there was a schedule for refreshing this training when it was required. Staff received supervision and appraisal.

The registered provider sought consent to provide care in line with legislation and guidance. We saw that care plans were signed by the people using the service.

People were supported to maintain good health and access healthcare services. We saw evidence in care files of contact with other healthcare services, such as chiropodists.

People consistently told us that the staff who supported them were very caring and that they felt involved in decision making about their care. There was a small staff team so people using the service knew their staff well. People also reported that they felt their privacy and dignity were respected.

All of the people using the service had a care plan, which they had been involved in developing and which was regularly reviewed. We found that care plans contained comprehensive information about peoples' needs and information about the support provided by staff, although some care plans lacked detail about

peoples' individual preferences in relation to how they liked their support. Staff were aware of peoples' preferences.

People were actively supported and encouraged to take part in social and leisure opportunities where they wished to do so. People could attend regular coffee mornings, activities and residents meetings and these provided opportunity for social interaction and for people to feedback on the service provided. There was also a complaints procedure in place and people using the service told us they knew how they could raise a complaint and that they would feel comfortable doing so.

People using the service, and the staff, told us that the registered manager was approachable and that the service was well led. There was a quality assurance system in place, including audits of the service and user satisfaction surveys. This enabled the registered manager to identify issues and measure the delivery of care.

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.

There were good systems in place to protect people. Staff had been trained in safeguarding vulnerable adults and knew how to report abuse. Risks to people were appropriately managed.

There were robust recruitment processes and appropriate checks completed before staff started work. There were sufficient staff to meet peoples' needs.

Systems were in place to ensure that people received their medication safely.

Is the service effective?

Good

The service was effective.

Staff were up to date with their training and felt confident that they had the training they needed to carry out their roles, and could request any additional training or support if they needed it.

People using the service were asked for their consent to their care and had signed their support plans.

People were supported to maintain good health and access health care services when they needed them.

Is the service caring?

Good

The service was caring.

People told us that staff were caring and they had positive caring relationships with the staff who supported them.

People using the service were involved in decisions about their care and felt that their views were acted on.

People we spoke with felt that staff respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Peoples' needs were assessed and care plans were in place to enable staff to provide personalised care. People were involved in developing and review their care plans.

There were systems in place to manage and respond to complaints and concerns.

Is the service well-led?

Good

The service was well-led.

The registered manager promoted a positive and person centred culture by providing a range of opportunities for people to provide feedback on the service they received.

The registered manager was accessible and visible to staff and to people who used the service. The registered manager provided staff with the support and resources they needed to deliver the service.

There were effective quality assurance systems in place.

Stamford Bridge Beaumont DCA

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 registered 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 29 February 2016 and was announced. The registered provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the location offices when we visited.

The inspection was carried out by two Adult Social Care Inspectors.

Before our visit we looked at information we held about the service, which included notifications sent to us. Notifications are when registered providers send us information about certain changes, events or incidents that occur.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of this inspection we spoke with four people who used the service, two members of staff and the registered manager. We looked at five people's care records, three staff recruitment and training files and a selection of records used to monitor the quality of the service.

Good

Is the service safe?

Our findings

People using the service told us "I feel very safe; I have the comfort of knowing there is someone around", "They look after me", "I feel safe and have no problems or complaints" and "They are always there for you. You know you are not really alone".

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse. There was also a copy of the Local Authority's multi-agency safeguarding policy and procedures available for staff to refer to. All staff received training in safeguarding vulnerable adults from abuse. Staff we spoke with understood the different types of abuse that could occur and were able to explain what they would do if they had any concerns. One staff member told us "I would speak to the manager and we would ring the safeguarding team, and I would record what people told me". The company also had a whistleblowing policy and this was on display in the office. No safeguarding referrals had been made in the previous year, but the registered provider had a system in place to manage safeguarding concerns should these arise.

The registered provider completed assessments to identify potential risks to people using the service and staff. We reviewed care files for the five people who were using the service and saw that there was an appropriate range of risk assessments in place. We saw risk assessment in relation to people and the environment, such as risk assessments for falls, manual handling, medication, finances and environmental risks. We were told that risk assessments were reviewed every six months. We noted that most risk assessments were up to date, but in two peoples' files some of the risk assessments were dated between April and June 2015 so were overdue for review according to the registered providers' policy. We discussed this with the registered manager who told us these would be reviewed. The general service risk assessment, which considered broader environmental risks that were applicable across the whole service, was up to date and appropriately completed.

Accidents and incident records were stored in individual care files. The registered manager also logged each accident or incident on to the provider's electronic clinical governance system, and signed them off to confirm that all appropriate action had been taken at that point. The clinical governance system was a database used to record and monitor aspects of service provision and risk. The registered manager conducted an analysis of any trends or patterns relating to accidents and incidents at the end of every month. We were also told that the regional director and the company's clinical development nurses also accessed these records, to monitor any concerns or patterns and provide guidance on specific areas, such as pressure care and falls. This showed us that there were effective systems in place to respond to accidents and incidents in order to keep staff and people using the service safe.

The registered provider had a safe system for the recruitment of staff. We looked at recruitment records for three staff. We saw that appropriate checks were completed before staff started work. These checks included seeking references and completing a Disclosure and Barring Service (DBS) check. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safe recruitment decisions and prevent unsuitable people

from working with vulnerable groups. The registered provider also required applicants for this service to have their National Vocational Qualification (NVQ) Level 3 in Care. NVQs are competency based qualifications. By completing these checks we could see that the registered provider was taking appropriate steps to ensure the suitability of workers.

We talked to the registered manager and staff about the availability of sufficient staffing to meet the needs of people using the service. The registered provider completed an assessment of the person's needs before delivering a service, to ensure they could meet their needs. As a small agency, there were two regular members of staff who provided the majority of the care, plus two bank staff members who provided cover where required. We were told "I have two carers, they always turn up… they never seem rushed".

There was a call bell system for the service, so people could use this to call for assistance from staff, including out of hours and in an emergency. Between 6pm and 8am the call bell alerted the nurse on duty in the care home, which adjoined the assisted living complex. Staff at the home established what the emergency was, acted in a 'good neighbour' capacity, and called family and/or 999 if it was a health emergency. People also had access to 24 hour maintenance on-call, for any issues with the property. People who used the service told us "I have got a call button in an emergency; they always come and test the call bell every week".

The registered provider had a medication policy in place and staff had received training on medication management. We saw that medication audits were completed every two months by the care coordinator and these were also checked and counter-signed by the registered manager. We also saw regular checks of medication stock levels. Staff confirmed that the registered manager completed annual observations of their medication practice. We saw records of these medication competency assessments, which showed that they were effectively used to monitor and ensure that staff were administering medication safely and in line with guidance on best practice.

One person using the service required assistance with medication and the level of support required was detailed in their care plan. This included information about where the medication was stored, the time it was required and the arrangements regarding the ordering of medication. We looked at the Medication Administration Records (MARs) for this person and found that these were appropriately completed.

This showed that there were systems in place to ensure people received their medication safely.

Good

Is the service effective?

Our findings

People using the service told us "Carers certainly seem to be very keen about learning", "They are excellent – first rate" and "They [staff] are extremely good; efficient and friendly and kind".

We saw that staff had a range of training to help them carry out their roles effectively. This training included health and safety, manual handling, fire safety, medication management, safeguarding vulnerable adults, mental capacity act, first aid and infection control. Records showed when staff had completed this training and there was a schedule for when this training would need to be refreshed. There was also a training calendar showing the up-coming training courses that staff could access. Staff told us "The training is very good… we are spot on with our training and up to date" and "I feel like I get enough training".

As the staff at this service had worked there for a long time, it was not possible to view recent evidence of staff induction records. The registered manager advised us that all new starters had an induction file and completed a comprehensive induction. New starters shadowed other staff for two to four weeks, depending on their experience, and dependant on when all their training had been completed.

We saw evidence of staff supervision, covering a range of appropriate topics, along with evidence of staff appraisal and team meetings. A staff member told us "I have supervision with [registered manager] three or four times a year, and an annual appraisal. We discuss things like any training needs, new residents, updates on peoples' needs, policies and any queries or concerns". This showed that people received care from staff that had the knowledge and support they needed to carry out their roles.

The Mental Capacity Act 2005 (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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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.

We checked whether the registered provider was working within the principles of the MCA. We were told that everyone using the service had the capacity to make decisions, but that one person had been experiencing some difficulty and fluctuating confusion with their medication. We noted from this person's care file that a capacity assessment had been completed and it had been agreed that this person would have a medication safe and receive support from staff to manage their medication. It was not clear from the paperwork whether this decision had been taken in the person's best interests, as governed by the MCA, or whether they had consented to this themselves, but staff were able to clarify that this was not made as a best interests decision as the person had capacity to make the decision and had consented to this.

Although we could see that capacity assessments were completed, staff we spoke with were not always able

to demonstrate a confident understanding of the Mental Capacity Act. However, staff we spoke with said they would ask for advice if they had concerns about someone's ability to make decisions. When we discussed this with the registered manager she said they would provide further guidance and support for staff in this area.

We saw that care plans were signed by the people using the service. Staff demonstrated an understanding of the importance of gaining consent, and said that the people they were supporting would be able to tell them if they weren't happy with something. Staff were also aware that information about people's consent to care was held in their individual care files. This showed us that the registered provider sought consent to provide care in line with legislation and guidance.

None of the five people supported by the service required a specialised diet or were at identified risk of malnutrition. Peoples' care files contained a section regarding any support required with shopping, eating and meals; this included information about peoples' food preferences. Most people did not need specific support in this area, as they were able to prepare their own food and eat independently. People also had the option to have a hot meal from the care home that adjoined the assisted living complex and some people chose to do that. People told us they were asked for feedback about the food in a survey.

People were supported to maintain good health and access healthcare services. We saw evidence in care files of contact with other healthcare services, such as chiropodists. We also saw an example of a GP being called for someone when they were feeling unwell. People who used the service told us "You can ask carers if you need a doctor and they can sort it out for you" and "They called an ambulance when I was unwell". This showed us people were able access healthcare services when needed.

Good

Is the service caring?

Our findings

We asked people using the service if staff were caring; feedback we received was consistently positive. One person we spoke with said the staff "Are very caring" and said "The care is very good. I get looked after…I get on well with the carers." Other people told us "They are always kind to you" and "[staff member] is very professional, always bright and breezy, a very cheerful person. We can always have a laugh; we talk about the grandchildren and all sorts of things really". Another person told us "We have quite good chats; I get on well with them socially and professionally". It was evident from these and other comments that people using the service had positive caring relationships with the staff.

The registered provider employed two staff who completed the majority of all the care and support provided. This meant that people using the service had regular support from staff they knew and who knew them. Staff told us that they knew residents very personally because they worked with them on a one to one basis. This consistency enabled people using the service to develop positive and meaningful caring relationships with the staff that supported them.

People had choice and control about their care and felt their views were acted on. One person told us "They respect my decisions, for example I didn't want a bath and they were okay with that". We found that there were also examples in care files where peoples' choices had been respected; one example of this was a risk assessment for someone that identified a loose rug as a potential hazard, but the individual had expressed that they would prefer to leave the rug down anyway and this choice was respected.

We saw that people were involved in their care planning and that their independence was promoted. Some people owned their own flats and others rented their property. People using the service received varying levels of support and were able to agree the number of calls they required each day from staff and the support they needed. For instance, one person told us "I just have assistance with a bath".

Nobody using the service had an advocate at the time of our visit, but the registered manager told us that they provided people with information about two local advocacy services, and information leaflets about these services were available in the reception of the assisted living complex. We were told that most people using the service had involvement from family and friends.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs but these were adequately provided for within people's own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

The registered provider had a policy regarding privacy dignity and service user rights, and people using the service told us they were treated with dignity and respect. We observed that staff knocked before entering people's flats and spoke with people in a kind, professional and respectful manner. Staff we spoke with

understood the importance of respecting peoples' privacy and dignity and were able to explain how they put this into practice. One member of staff gave examples such as standing outside whilst people were showering, or wrapping people with towels when supporting with personal care to maintain their dignity. One person using the service told us "They treat you with dignity and respect… if you need anything you can ask them".

Confidential information about people using the service was stored in people's own property or in a lockable filing cabinet within the locked office, which meant that it was held securely.

Good

Is the service responsive?

Our findings

All of the people using the service had a care plan, which they had been involved in developing. One person using the service told us "When you arrive [the care coordinator] comes in and goes through the care plan with you. I have been asked to sign my care plan and they tell you what they've written".

We saw that an assessment was completed prior to people using the service. Staff told us that when considering moving into the assisted living flats new people had a look round, then the care coordinator went out to do a full assessment regarding peoples' needs; which included their strengths and levels of independence, and suitability for assisted living.

We saw that care plans were developed when people started using the service, and staff told us "We sit and chat, we ask loads of questions about people's life history when doing the care plans, including peoples' likes and dislikes". Care plans included information about peoples' needs in relation to communication, personal care, continence, mobility, medication, shopping, eating and meals, mental wellbeing and cognition, social interests and hobbies and spiritual and cultural needs. We saw that people had signed their care plans. We found that there was comprehensive information about peoples' needs and information about the support provided by staff, although some sections within care plans lacked detail about peoples' individual preferences in relation to how they liked their support. When we spoke to the registered manager about this they told us that staff knew the people they supported very well and that they would review the information in the care files to ensure these included information about peoples' preferences, so that all staff, including those who provide cover in the absence of the regular care staff, were aware of this information.

People were involved in reviews of their care plans and we could see from the records held that care plans were reviewed and updated regularly. This was confirmed by people using the service, as we were told "I have a green care plan, which they update regularly and we go through it together". There was also flexibility when people wanted a change to their regular time slot, and staff told us "We work around their needs and are flexible if they are going out. We are super flexible".

People were actively supported and encouraged to take part in social and leisure opportunities where they wished to do so. We saw that regular coffee mornings were held and that people using the service could access any of the opportunities on the activities programme run by the registered provider within the care home which adjoined the assisted living complex. These were well advertised around the building and people who used the service commented "I get invited to events and activities, but there's no pressure to go". We also saw evidence in residents meeting minutes about discussions regarding activities and the opportunity for trips out using a local coach company. There was also evidence in resident meeting minutes of where the registered provider had promoted the opportunity to attend other externally organised activities in the community, or pursue individual interests.

There was a complaints, suggestions and comments policy and procedure in place and a system to record and respond to complaints. Records showed that there were no formal complaints or compliments about

the service in the last year. We did however note examples of compliments and positive feedback in care files and user satisfaction surveys, but these were not recorded as formal compliments. The complaints procedure was displayed in the reception area of the assisted living complex and there was also a comments box for people who used the service or for visitors and relatives. People were aware of how they could make a complaint and told us they felt able to raise concerns "I would tell [care coordinator] if I needed something or had any problem…I would feel quite happy to complain if I needed to". Other comments from people using the service included "I don't have any complaints" and "I think it [the service provided] is very well done. I couldn't see that there is anything that could be changed. I can't imagine a better place than this".

This showed us that concerns and complaints were encouraged and that there was a system in place to respond to complaints.

Good

Is the service well-led?

Our findings

When we spoke with people who use the service they were unanimously positive about the service provided and one person told us that "It seems well-led". Another commented that "[The registered manager] is very friendly".

We saw minutes of residents meetings, which showed that people had regular opportunity to raise concerns or suggestions about the service. We saw examples of issues raised that were being addressed by the registered manager, such as an issue about trees outside the property, which was being pursued at the time of the inspection. There were also regular coffee mornings and we were advised in the Provider Information Return that the registered manager attended these coffee mornings four times a year to ensure they were visible and accessible to all.

We saw results of a user satisfaction survey which was sent out in January 2015. The findings of this survey had been collated and discussed at a residents meeting in March 2015. We saw that action had been taken as a result of comments in the survey, such as advising residents that the service user welcome pack was under review and would be published so that existing residents could have a copy. The welcome pack was a set of key information given to people when they started receiving support from the service, including the services available. The registered manager advised us that the registered provider was in the process of reviewing the company's user satisfaction survey, so in the meantime, a shorter interim survey had been sent out to gain feedback. A staff satisfaction survey had also been sent out and at the time of the inspection the registered manager was awaiting the feedback from this survey.

The registered provider had a mission and values statement and we saw team meeting minutes that showed that the mission and values of the organisation had been discussed with staff.

This all showed us the service promoted a positive and person centred culture.

There was a registered manager in post at the time of our inspection and they had been in post for three and a half years. The staff we spoke with said they felt supported; one told us "I have an excellent manager; they are so supportive and reassuring. The best manager I have ever had. If I want something or need advice, they always have time for me".

The registered manager advised us that they kept up-to-date with guidance on best practice by attending the local Clinical Commissioning Group care home forum, attending local nursing home forums in York and East Riding and through training provided by the local authority and Social Care Institute for Excellence. The registered manager also told us they followed Skills for Care, the Nursing Times and Nursing and Midwifery Council publications, along with internal meetings and briefings from the registered provider about best practice and regulations. The registered manager advised us that they shared relevant information about best practice and regulations with staff in team meetings and we saw an example of this in team meeting minutes.

We saw evidence of team meetings; some of these were with the whole team and others were between the registered manager and care coordinator. Topics discussed included resident reviews, risk assessment reviews, lessons learned since the last meeting and improving communication. Staff from the service also attended the daily 'heads of service' meetings each morning, with other staff from the adjoining care home. We also saw records of supervision and appraisal meetings with staff and annual competency assessments, where feedback was given to staff on their performance. This showed us that there was good leadership and management of the service.

In addition to user satisfaction surveys there were a range of other quality assurance tools and audits in place. The provider completed bi-monthly 'Quality First Visits', which audited the service against the five key questions that the Care Quality Commission look at when they are inspecting, namely; is the service safe, effective, caring, responsive and well led. We saw that the last Quality First Visit was completed by the registered provider in November 2015. The registered manager advised us that the audit was now slightly overdue because of a change in regional management, but that the new Regional Director was scheduled to visit the service the day after our inspection to complete the next one. We saw examples in previous registered provider audits where issues had been identified and addressed, such as bringing training up to date and making staff more aware of the whistleblowing policy. There were also bi-monthly medication audits and we saw that these were completed by the care coordinator and checked and counter signed by the registered manager. We also saw a range of environmental checks and audits, health and safety meeting minutes and annual competency checks for staff. There was a system to record accidents and incidents and a complaints procedure, which enabled the registered provider to learn from incidents and complaints.

The service had policies and procedures in place and these were currently under review. A new governance system had also been introduced by the provider in January 2016. This meant that the registered manager was able to use the electronic clinical governance system (a database used to monitor aspects of service provision) to run separate reports for this service, from the adjoining care home, which meant that they were able to analyse data and patterns in more detail.

We asked for a variety of records and documents during our inspection. Overall we found these were well kept, easily accessible and stored securely.

This showed us that there were effective quality assurance systems in place and this meant the registered manager was able to measure and review the delivery of care.