Compleat Care (UK) Limited

Five Bells Residential Care Home

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?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We undertook a comprehensive inspection on 7 and 8 August 2018. The inspection was unannounced.

Five Bells Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service is registered to provide accommodation for up to 28 older people or people living with a dementia type illness or a physical disability. There were 23 people living in the service during our inspection. Two people were living in the service under a tenancy agreement and did not receive personal care from the provider. We have not referred to these people in our inspection report. Eleven people lived in the main house; an adapted three storey property and a further 12 people lived in adjacent apartments and mews houses.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are registered persons. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection of Five Bells Residential Care Home in April 2017 we found a breach of the regulations and the service was rated 'Requires Improvement'. This was because the registered provider failed to ensure that people were kept safe from the risk of harm. At this inspection we found that some improvements had been made and the service was now rated 'Good.'

Staffing levels had improved for some staff groups and staff had security checks prior to starting work to ensure that they were appropriate to care for people. Medicines were administered by competent staff. All areas of the service were clean and ongoing improvements were being made to the environment.

People received care and support from staff who understood their care needs. The delivery of care was coordinated and person-centred. People were provided with their choice of food and drink. Staff referred people in a timely manner to other healthcare professionals when their condition changed. Staff followed the guidance in the Mental Capacity Act 2005 and people were lawfully deprived of their liberty.

People were enabled to be involved in planning their care. Staff focused their care on the individual person. People were treated with kindness and compassion. However, some staff did not consider an individual person's dignity.

People received care that was responsive to their individual needs and preferences. Systems were in place to enable people to make a complaint if they wished to do so. Staff respected a person's end of life care needs and wishes.

Quality monitoring systems were in place.

People spoke highly of the care they received and the attitude of staff. Staff enjoyed working at the service and were proud of their achievements

People who lived in the service and staff had a voice and were supported to give their feedback on the service. The registered manager was proactive and had made significant improvements to the standards of care in the service.

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 not consistently safe.

The provider did not ensure that there were appropriate numbers of housekeeping and catering staff.

Staff ensured people received their medicines safely.

Staff were aware of safe infection control practices. However, some areas required decoration.

People were cared for by staff who were aware of safeguarding and knew how to escalate their concerns.

Is the service effective?

Good

The service was effective.

Staff understood and followed the principles of the Mental Capacity Act 2005. People gave their consent to care and treatment.

People received a varied, nutritious and balanced diet.

People had access to health and social care professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect.

Staff were kind and caring.

People had their human rights maintained by staff and were protected from discrimination.

Is the service responsive?

Good

The service was responsive.

Staff enabled people to maintain their independence.

People had their care needs assessed and were involved in decisions about their care.

People at the end of their life were supported to have a comfortable, pain free and dignified death.

Is the service well-led?

Good

The service was well-led

The registered manager was a visible and approachable leader.

Quality monitoring systems were in place.

People were able to give their feedback on the care they received and were invited to attend regular meetings with the registered manager.

Five Bells Residential Care Home

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 7 and 8 August 2018 and was unannounced and the inspection team was made up of one inspector.

Before our inspection we gathered and reviewed information we held about the service such as notifications (events which happened in the service that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams.

During our inspection we spoke with the registered manager, managing director, three team leaders, a senior carer, three members of care staff, the cook, the housekeeper and six people who lived at the service. We also spoke with visiting friends and one visiting healthcare professional.

In addition, we looked at several areas of the service to see what improvements had been made to the environment since our last inspection. These included shared areas, the medical room, individual bedrooms, flats and mews houses and communal toilets and bathrooms.

Before our inspection we requested a Provider Information Return (PIR). A PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. The provider sent us the requested PIR.

We looked at a range of records related to the running of and the quality of the service. These included three

staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager had completed. We also looked at care plans and daily care records for seven people and medicine administration records for seven people who lived at the service.

Good

Is the service safe?

Our findings

At our last inspection in April 2017 we found the provider to be in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were shortfalls in some of the arrangements that had been made to reduce the risk of people experiencing avoidable harm. At this inspection we found that the provider had made significant improvements and was no longer in breach of regulation 12.

At our last inspection we found a security issue in relation to access to the accommodation that had not been managed or addressed. Another issue was two radiators had not been fitted with suitable guards. A further issue was that some of the windows were not fitted with safety latches to prevent them from opening too far. This increased the risk that people would be injured or come to harm. On this inspection we found that significant improvements had been made. These included improvements to security, making the radiator fixtures safe and attaching safety latches to the windows. These measures supported staff to keep people safe from the risk of harm.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question, 'How are risks to people assessed and their safety monitored and managed so they are supported to stay safe and their freedom is respected' to at least good.

Staff were aware of how they would keep people safe, and were able to identify signs of abuse, such as changes in a person's mood or unexplained bruising to their skin. In addition, staff told us how they would share their concerns and one member of staff said, "I would tell the manager or the team leader. There is a number we can phone, it's in a book in the office."

Systems were in place to identify and reduce the risks to people living in the service. People's care plans included detailed and informative risk assessments. These documents were individualised and provided staff with a clear description of any risks and guidance on the support people needed to manage risk. Staff understood the support people needed to promote their independence and freedom, yet minimise the risks. For example, one person liked to walk to the local shop. This involved crossing a main road. The person had their road safety and awareness assessed.

We observed that there was a lack of suitable storage space for equipment such as wheelchairs and hoists. There were six wheelchairs that were not currently in use stored in a corner of the conservatory. This was a hazard as some people chose to take their lunch in this area. The sit on scales were stored in the corridor outside the office, blocking access to the fire extinguisher. We brought this to the registered manager's attention who had the scales moved into the main lounge. During our inspection a senior member of staff identified a recess in the main lounge that could be used to store equipment.

We saw that the provider had up to date certificates to confirm that essential safety checks had been carried out to keep people safe. For example, electrical appliance testing, fire safety and water safety. People and staff were aware of the action to take in the event of a fire or other emergency and people had individual

personal emergency evacuation plans in place. The 'old school' had been identified as a place of safety to evacuate to.

The head cook told us that there were not enough kitchen staff and said, "I could do with an extra hand to dish up and clear away." We also found that the kitchen assistant prepared sandwiches before they went off duty at 3pm. After this time care staff were responsible for cooking and serving the evening meal.

The registered manager told us that the service was not dependent on bank or agency staff to cover for unplanned absences as there were enough permanent staff to cover. However, senior care staff told us of their experience when members of staff were off sick. One team leader said, "It's hard work, especially if staff sickness. We have no bank or agency [staff] and the shifts are not always covered. The manager is aware."

We looked at the recruitment files for three staff who had been appointed since our last inspection. Systems were in place to ensure that staff were not appointed to post until at least two references had been received; including one from their previous employer. All staff had been subject to criminal record checks before starting work at the service. These checks are carried out by the Disclosure and Barring Service (DBS) and helps employers to make safer recruitment decisions and prevent unsuitable staff being employed.

Robust systems were in place for the safe ordering, storage, administration and disposal of medicines. We found that people's medicines, including controlled drugs were managed consistently and safely by competent staff.

We looked at medicine administration records (MAR) for eight people and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a photograph of the person for identification purposes and any allergies and special instructions were recorded. For example, one person had time specific medicines to be taken one hour before or two hours after food. Some people were prescribed as required medicine, such as pain relief, and staff had access to protocols to enable them to administer their medicines safely.

Where a person was able to look after their own medicines we saw that all safety checks and risk assessments had been carried out and the person had given their signed consent to self-administer.

We spoke with a housekeeper who was proud of their role and achievements in maintaining a good standard of cleanliness, all areas of the service were clean. We saw that good infection control practices were adhered to. All staff had attended infection control training, had access to policies and procedures that reflected national guidelines and had access to personal protective equipment. Standards of cleanliness in the home were regularly assessed by a registered manager and the housekeepers completed a daily record of cleaning duties undertaken.

People told us that they were happy with the standard of cleanliness in the service, but the home would benefit from being painted. One person told us that staff had cleaned their bedroom the previous day and said, "They cleaned it, bottomed it out yesterday. They cleaned the windows and pulled my bed out. "However, we noted that the wall behind their bed was damaged and the paint work on their skirting board was scuffed.

The sink in the staff toilet was cracked. This provided an environment for bacteria to grow and there was a risk of cross-contamination. We noted that a replacement sink had been purchased some time ago, but had not been fitted and was stored on top of a cupboard in the office. We discussed this with the registered manager who confirmed that the sink would be replaced as a priority.

We found that the registered manager had acknowledged our feedback and rating of 'Requires Improvement' from our last inspection and had made improvements to the safety of people who lived in the service. We have therefore rated this domain as Good on this inspection.

Good

Is the service effective?

Our findings

People were encouraged to personalise their bedrooms and apartments to make them homely. One person who had recently moved into the service told us, "I'm very comfortable, but I would have liked a bigger room, but, I have my mirror, my photographs and my TV." We noted that their bedroom lacked storage space and the floor was cluttered with bags and boxes of their belongings.

The environmental maintenance plan acknowledged that some people living in the service had mild to moderate cognitive difficulties. The aim of the plan was to enable people to live in an environment that was 'dementia' friendly. We saw that this was a work in progress, and brought to the registered managers attention that the floor in the corridor leading to the dining room was sloped and there were no signs to alert people to this.

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 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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

Prior to our inspection we requested and received information from the local authority mental capacity team about the number of current DoLS authorisations granted to people living in the service. Two people were currently being lawfully deprived of their liberty. The recently appointed registered manager was unaware that the previous registered manager had not submitted statutory notifications to notify us of the DoLS authorisations. The registered manager submitted these notifications on day one of our inspection. Therefore, we found that the provider was working within the principles of the MCA.

Care staff were aware how to obtain consent from people when providing personal care. One staff member said, "Even when a person has dementia, I still ask them what they want to wear."

Before a person moved into the service the registered manager undertook a full assessment of their physical, social, psychological, cultural and spiritual needs. Risk assessments and care plans were developed in accordance with their needs and preferences and regularly reviewed. When a person moved into the service for a short-term respite stay or as an emergency they also had their needs and preferences assessed.

The service had an in-house trainer and a designated training room. We looked at the staff training matrix and saw that staff had attended mandatory training in key areas such as health and safety and infection control. In addition, some staff had undertaken training in topics relevant to their roles and level of responsibility, such as diabetes awareness and palliative care. We looked at individual training records for three members of staff. We found that newly appointed staff were enabled to undertake the Care Certificate, a 12-week national programme that covered all aspects of health and social care.

We looked at the training room and saw that staff had access to policies and procedures and up to date national guidance on subjects such as, Mental Capacity Act 2005, safeguarding and nutrition.

Some staff had taken on lead roles for key topics such as nutrition, hydration and continence. However, members of staff had yet to be identified to take the lead for infection control, dementia and dignity. The registered manager informed us that these outstanding areas would be allocated through supervision. We saw that staff received regular supervision sessions from the registered manager, records were maintained and areas for improvements and professional development were identified. The registered manager had only been in post a short time and had not yet carried out any annual appraisals with staff.

People told us that the food was good. One person shared their personal story with us, "My appetite has improved since I moved in. I've put on weight. The food is to my taste. The cook comes and talks about food with me. I gave the cook my recipe for bubble and squeak. I love food." Another person told us, "The food is very good." People were provided with a varied, nutritious and balanced diet and were offered a choice. A pictorial breakfast menu was on display in the dining room, but there was no information on display to assist people to make their lunch and tea choices. The head cook told us that they were aware of individual likes and dislikes and provided a choice at each meal and also provided alternatives to the main menu. For example, salads, baked potatoes and omelettes. The head cook said, "We ask daily what they want for lunch and tea tomorrow. There is always a choice of two main courses and I make a fresh soup every day." We found that since the registered manager was appointed that catering staff used more fresh food and meat and vegetables were locally sourced.

The weather was warm and people were regularly offered hot and cold drinks throughout the day. In addition, a trolley was set up in the dining room with flasks of hot and cold water where visitors and people who were able, could help themselves.

A community healthcare professional told us about a person who had recently moved into Five Bells Residential Care Home on discharge from hospital. We found that the person would have preferred to return to their own home rather than move into the care home, but was unable to do so at present. Care staff worked in partnership with the person and their community team to enable a safe and smooth transition into the service. We saw that the person had settled into the service, had made new friends and now wanted to reside there permanently.

Staff supported people to access their healthcare professionals, such as their GP, dentist and clinical nurse specialists. In addition, people were visited every six to eight weeks by a chiropodist.

Requires Improvement

Is the service caring?

Our findings

People told us that they were happy living in the service. One person said, "I have made friends here. I was very isolated at home as my family live away. I've found my home from home. I just adore it." Another person said, "I am happy and content and well looked after." We observed people interacting with each other and with staff in the lounge and other shared areas. People were at ease with each other and we witnessed lots of friendly banter between people and staff. Care staff told us that the service had a friendly, family culture. Our observations supported this comment.

People were looked after by kind, caring and compassionate staff. We observed care staff assist to their table in the dining room for lunch. Staff supported people at their own pace, offered words of encouragement, asked them if they were comfortable and thanked them for their cooperation.

Some people had their own mobile phone and/or laptop and could maintain contact with family and friends through various forms of social media whenever they wanted to. One person told us that the provider had helped them access the internet and said, "I was the only 'Silver Surfer' when I moved in here. The provider got a specialist in to get me connected."

People were enabled to express their views and be actively involved in decisions about their care. They were included in their risk assessments and planning their care with their key worker. The registered manager had recently introduced a 'life story book'. People were enabled to record their life story and share their story with staff who cared for them. This helped staff understand the person's previous life events, including their childhood, careers and children.

Staff had access to guidance on how to protect people from discrimination and promote their equal rights. However, staff did not always treat people with dignity or respect their individual needs and abilities. At lunchtime we observed a member of care staff take a bowl of food and a fork to a person in their bedroom. They did not carry their lunch on a tray or offer them a napkin or condiments. We asked why their main course was presented in a bowl and were told that it was because the person ate small bites. We brought this to the attention of the registered manager who requested that the person's meal be presented in an appetising and respectful way. A few minutes later another member of care staff returned with the person's lunch presented on a dinner plate on a tray. We then brought to the registered managers' attention that the plastic drinking cup the person was provided with was stained and badly scratched inside. The registered manager replaced this with a clean cup.

In the dining room we observed a person with dexterity difficulties struggle to eat their meal as they were unable to place the food on their cutlery without it falling off their plate. We noticed this person's frustration and informed the registered manager. The registered manager showed us a plate called a 'pea pusher' that had a lip to prevent food from spilling over onto the table. This plate was specifically for the person who had dexterity difficulties. Staff had failed to treat people with dignity and respect.

Good

Is the service responsive?

Our findings

People had their care needs assessed and personalised care plans were introduced to outline the care they received. Care was person centred and people and their relatives were involved in planning their care. We saw that individual care plans focussed on supporting a people to live well and maintain their optimum level of independence and well-being. Team leaders were responsible for reviewing care plans once a month and ensured that they were up to date and reflected individual needs and choices. All care staff had access to care plans and were encouraged to read them. Two team leaders told us that the format of the care files had been revised by the registered manager and were much improved. One said, "Individual care plans are now easier to find. They are more in-depth." The other team leader said, "When we call 999 and they ask questions, we can find the answers straight away." This meant that people received care in response to their needs in a timely manner.

We observed part of the afternoon handover and found that staff shared information about individual care needs to maintain continuity of care. One staff member said, "We share what the next team on duty should do." In addition, staff had a daily diary and communication book.

People were supported to maintain their interest in the outside world. For example, several people had requested a daily newspaper and a member of staff collected and distributed these each morning. One person said, "I have my Sunday newspaper delivered and my TV magazine on a Tuesday."

There was an activity coordinator on duty three days a week. They were not on duty during our inspection, however, most people were engaged in individual past-times of their choice. One person was knitting, and another person was sketching. This person told us that they were always busy and said, "I attend a local art club with my friend. I go to church and have a coffee afterwards." Several people were discussing with a member of care staff the film that they would like to watch later that day.

We found that people were enabled to maintain their independence and feel involved. One person told us that they had help prepare the vegetables for Christmas dinner. Another person showed us round the garden, and said, "I look after the garden. It keeps me busy. I'm supported to buy plants from a local garden centre. I have a lot of independence."

People were encouraged to personalise their bedroom, flat or mews house and make it homely and reflect their lifestyle. We saw that most people had photographs and ornaments from home and several people had personal items of furniture.

Special events were celebrated and people were encouraged to participate in them. Several people shared the fun they had at a street party to celebrate a recent Royal wedding. One person said, "We could invite friends. We had a long table in the lane [outside]. It was a fabulous street party. We had a wedding cake"

Staff told us that they would escalate any complaints or concerns shared with them to the team leader. The provider maintained a record of all complaints and compliments received. People had access to the

complaints policy and procedures that signposted them to external agencies such as the Local Government Ombudsman. The people we spoke with told us that they would not hesitate to raise concerns with staff or the registered manager, but had not needed to do so. We noted that there had been no formal complaints made in the previous 12 months.

The registered persons ensured people were protected under the Equality Act 2010 and they had a knowledge of the Accessible Information Standard, which applies to people who have information or communication needs relating to a disability, impairment or sensory loss. We noted that one person who was partially sighted had their own telephone with large print numbers to help them dial independently.

Staff understood the importance of supporting people and helping them prepare for care at the end of their life according to their wishes. People were supported to record their final wishes and preferences on an advanced care plan, such as where they wanted to die and their funeral wishes.

We saw that staff involved other healthcare professionals to support individuals to have a comfortable, dignified and pain free death. For example, one person's GP had prescribed anticipatory drugs to be used when needed to keep the person comfortable and pain free at the end of their life. Another person had the support of a specialist nurse to help remain in the service rather than go into hospital at the end of their life. We spoke with the specialist nurse who explained that they visited the service at least once a week and that people near the end of their life were also supported by health professionals from the local hospice.

Good

Is the service well-led?

Our findings

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We observed that the registered manager was a visible leader and people and staff and external professionals spoke positively about them. Staff shared that there had been improvements made since the registered manager had taken up their post. For example, one member of care staff said, "There has been a big difference since [Name of registered manager] came. They have changed everything for the better. We work as a team." Another staff member said, "[Name of registered manager] is very good, approachable and enthusiastic." A visiting healthcare professional told us that the registered manager was a visible leader and added, "[Name of registered manager] is a powerful influence, things are better now."

Staff had a code of professional conduct to follow, to ensure that they acted in a professional manner. Key documents such as the Service User Guide, the Statement of Purpose, whistleblowing policy and mission and quality statements were accessible to people, their relatives and friends and staff.

We saw that staff were invited to attend regular staff meetings with the registered manager. One member of care staff said, "We are given feedback on incidents and have a chance to speak up." Another member of staff told us, "At staff meetings, we share our opinions, everything is brought up. We have separate team leader meetings." We found that all staff groups met with the registered manager and meeting minutes were signed off by all staff as read and agreed. We saw that the topics discussed were pertinent to each staff group.

People were invited to give their feedback on the service through the annual residents' survey. Relatives and residents attended group meetings with the registered manager. We looked at the minutes of the meeting held in April 2018 and noted topics discussed included, staffing levels, menus and care plans. Furthermore, people, their relatives and staff were kept up to date with events in the service through a regular newsletter. We looked at the issue circulated in July 2018 and saw significant events were celebrated. For example, Father's Day, an Italian night, the World Cup and the gardening club trip to a garden centre.

The registered manager collated information from accidents and incidents and used this to amend care plans where necessary. In addition, the registered manager undertook an audit analysis of the findings from monthly audits. These included incidences of falls, infections and skin tears. However, the provider did not have formal system or process in place to escalate these findings to the provider or senior management team. This meant that there was a risk that the provider was not fully informed of the cause, frequency or severity of accidents and incidents to assess the impact on people who lived in the service.

The provider was a member of the Lincolnshire Care Association (LinCaA). LinCA provides members with regular newsletters, workshops and networking to enable them to keep up to date with current best practice

initiatives.