Bupa Care Homes (ANS) Limited

Manley Court Care Home

Inspection report

John Williams Close
Off Cold Blow Lane, New Cross
London
SE14 5XA

Tel: 02076354600

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Manley Court Care Home is a residential care home. At the time of the inspection the service was providing personal and nursing to 80 people, some living with dementia or physical and learning disabilities. The service can support up to 85 people. The accommodation was spread over four separate units all with communal living and dining areas.

People's experience of using this service
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Risks to people's health and wellbeing were assessed and individual risk management plans were put in place to help mitigate risks. We found when some people became agitated staff could not support them effectively and others sufficient details were not included in their care records to support them.

People shared mixed views of whether they were happy living at the service. While some people said they felt safe and staff were caring others said staff were too rushed during the day to ask for help. The numbers of staff available were not always at the provider's recommended levels to meet people's needs safely. People told us that they were not enough staff on duty.

There were systems in place for people to have their medicines as planned. However, we found that some aspects of medicine management were not robust.

There was a safeguarding policy and process and staff had completed training on safeguarding and protecting people from abuse. Records showed that safeguarding log was not always up to date. This meant there was a potential risk that people were not effectively protected from harm and abuse.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff followed infection control and prevention (IPC) guidance to protect people from infection including COVID-19. Staff wore protective personal equipment (PPE) and we observed the service was clean and hygienic throughout. The service's IPC and COVID-19 policies were up to date. Managers contacted their local health protection team in a timely way when they suspected a COVID-19 outbreak.

Rating at last inspection
The last rating for this service was requires improvement (Report published 8 July 2021).

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 8 March 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve the concerns about staffing levels, the quality of care records and the monitoring of the service.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe and well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement for the second consecutive inspections. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Manley Court Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service. We have identified continued breaches in relation to good governance and staffing and a new breach in safe care and treatment. We have made a recommendation in relation to person-centred care.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Manley Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection prevention and control measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors, a specialist professional advisor who is a registered nurse and two Experts by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. The service was being managed jointly between the deputy manager and clinical service manager. A new manager was recruited and due to resume the role as home manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and five relatives. We spoke with members of staff including the deputy manager, the clinical service manager, the regional quality manager, four nurses and six care workers. We reviewed a range of records. This included 10 people's care records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. After the inspection we received additional records from the provider in relation to this inspection.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

At the last inspection, we found staffing levels were not available at the provider's assessed levels to meet people's individual needs. This placed people at risk of harm and was a breach of regulation 18 (Staffing) of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that although some improvements had been made, not enough improvement had been made and the provider remained in breach of this part of regulation 18.

- There was an assessment completed to ensure there was enough staff available at the provider's levels to meet people individual needs. We found that although some changes had been made to improve the numbers of staff, concerns about staffing levels remained at this inspection.
- The manager sent us an action plan to address the concerns we found about staffing levels and how they would address them. However, we found the level of staffing was not consistent to meet people's needs.
- People gave us mixed views about the level of staff available to support them. Two people told us the service was understaffed and other people commented, "Sometimes there are enough staff and sometimes not" and "The staff are busy in the morning. Maybe there could be more staff at this time." This meant that there was a risk that people's individual needs might not be met.
- At the time of the inspection the staffing levels for each unit was one nurse and four care workers per day shift and one nurse and two care workers per night shift on each unit. This information was confirmed by the deputy manager.
- We found that from the 5th August 2022 to the 1st September 2022 there were seven occasions in total where the required numbers of care workers rostered to be on duty was less than planned. This meant there was a potential risk that people did not have their assessed care needs provided to them as expected. The staff levels fell short of the planned staffing numbers and this increased the risk of poor and delayed care which did not meet people's individual needs.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staffing levels were safely managed. This placed people at risk of harm. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Pre-employment checks took place to ensure staff had the necessary knowledge and skills. The checks included the right to work in the UK, job references and a check from the Disclosure and Barring Service.

Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Assessing risk, safety monitoring and management

●People's care needs were assessed before using the service but there was some inconsistency in the detail contained within risk assessments and risk management plans.

●The risk assessments identified risks to people's care needs, health and well-being. However, we found some risk management plans did not contain sufficient information to guide staff to support people safely.

●The risks related to people's specific needs did not always have effective plans in plan to manage these risks. We reviewed a person's care records where they were at risk of choking due to significant swallowing difficulties. We noted the person had a care plan in plan that had identified this risk and they had a choking risk assessment in place. The risk was recorded to be reviewed each month and we noted the last review was in April 2022. This meant that people might be at risk because sufficient guidance was not in place to support people who had identified risks.

●The service did not always have risk management plans in place for people with specific needs in relation to their mental health needs. We observed on three occasions were people were visibly upset and displayed behaviour that challenged staff and others. For example, a person was agitated and said, "I should not be here, I want to go/be back home, you don't know what's going on." The person was hitting themselves and was visibly upset. Staff attempted to support the person but the person remained agitated. We checked the person's care records and a referral was made to health care professionals for advice. They suggested staff should monitor the person and complete monitoring forms so behaviours could be recorded. The person's mental health needs were reviewed and their mental health care plan was updated by staff. We found this care plan lacked detailed guidance for staff on how to support the person to reduce their distress and when they showed and voiced their agitation.

We found no evidence that people had been harmed however, people did not always have risk management plans to safely manage risks to their health and well-being. This placed people at risk of harm. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Following the inspection the provider told us that they had updated the care plan for the person who expressed distress and agitation during the inspection.

Using medicines safely

●People had their medicines administered to help them maintain their health care needs. However, we found some concerns with other aspects of medicines management. For example, we found a used sharp bin did not have a date on it when it was first opened. Not all liquid medicines, inhalers and topical creams had a date on the packaging when these were first opened and used.

●We found that people were not always fully protected from the risks associated with medicines. For example, we noted that staff did not appropriately update a person's medicine administration record (MAR) when the medicine used to treat their health conditions was discontinued. While the medicine was crossed off the MAR, the entry was neither dated nor countersigned. This shortfall was in conflict with the NICE guidance, 'Managing Medicines in care homes'. This meant the systems in the home did not always ensure that people were protected against the risks that can arise if medicines are not well managed.

●There was no system in place to ensure equipment used to monitor people's blood sugar levels were calibrated and maintained. Staff used a blood glucose meter (BM) machine for people who had a diagnosis of diabetes to ensure their blood sugar levels were within acceptable ranges. We asked staff for records of

regular testing and maintenance of the BM machine. We were told there were no checks recorded. People were at risk of deteriorating health due to potentially poorly maintained equipment because of the failure to ensure the machine provided accurate readings and was well maintained.

The lack of accurate and robust medicines management increased the risk of harm to people's health and safety. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The service had a medicines policy that provided staff with guidance on the safe handling and administration of medicines in line with current best practice.
●Medicines were being stored, checked and disposed of in line with current guidance. Weekly and monthly medicines audits were completed to ensure people had their medicines as prescribed and any errors were detected and managed promptly.

Systems and processes to safeguard people from the risk from abuse
●People and relatives told us they felt safe receiving care and support from staff. Comments included, "I couldn't thank the staff enough" and "Yes I feel safe living here."
●Staff described what they had learnt in their safeguarding training and understood their responsibilities to act on abuse. Staff described how they would report a concern or an incident of abuse to the management.
●There was a safeguarding log which contained details of all safeguarding allegation that were reported. This record was not completely up to date and did not always contain details of investigation and the outcome. After some discussion with the deputy manager, all safeguarding incidents were found on the internal data base system with clear evidence of what had been done. We checked all safeguarding allegations had been reported to CQC appropriately.

Preventing and controlling infection

●We were assured that the provider was preventing visitors from catching and spreading infections.

●We were assured that the provider was supporting people living at the service to minimise the spread of infection.

●We were assured that the provider was admitting people safely to the service.

●We were assured that the provider was using PPE effectively and safely.

●We were assured that the provider was responding effectively to risks and signs of infection.

●We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

●We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

●We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
●All visitors and professionals were required to show evidence of their on the day COVID-19 rapid lateral

flow test result. A temperature check was taken and visitors and professionals were asked whether they had symptoms of COVID-19 before entering the home.

●Visitors were supported to have contact with their family members and friends. The service provided opportunities for safe visiting and maintain social distancing. This arrangement meant people could continue to maintain relationships with people they cared for which could have a positive impact on their health and well-being.

Learning lessons when things go wrong

●There were systems in place for the review and regular monitoring of the service.

●Records of accidents and incidents were recorded and escalated to the service manager for investigation and action, including any recommendations for the service to follow.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At the last inspection in March 2021 we found the lack of effective monitoring of the service and poor quality care and management records meant people did always receive a good standard of care. This was a breach of regulation 17 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that although some improvements had been made, not enough improvement had been made and the provider remains in breach of this part of regulation 17.

● The management records were not always appropriately maintained. The service kept a DoLS tracker to monitor people on DoLS authorisations to ensure these were in date. While the tracker was available for our review we found that it was not up to date. At the time of writing this inspection report we had not received a copy of the updated DoLS tracker.
●The management of the service demonstrated that risks to people and the service were not effectively assessed and monitored. Care records were not always updated to ensure people's needs were accurately assessed and reviewed.
●The deputy and clinical service managers were managing the home with the support from members of the provider's senior management team. At the time of the inspection, there was no registered manager in post at the service, they left the service without notice and without providing a handover to the team.
●Feedback from staff about the management of the service was positive. Staff told us that they felt the deputy manager and clinical service manager were both supportive, approachable and showed fairness to them. Comments we received were, "[Deputy manager] has really helped me in my role and they listen to me" and "The management has changed several times but I think this management team are really supportive and easy to talk to."
●The provider's managers gave the team support to carry out checks on the service to ensure it had improved and maintained standards. However, the checks and monitoring of the service failed to identify the concerns we found.

Continuous learning and improving care
●The provider had systems in place for learning and development at the service. The provider's manager

had identified areas for improvement highlighted in their quality improvement plan. This included the daily review of care needs of service users and the daily review of the staffing rotas to ensure proper management. However from our observations, discussions with people, staff and review of management records, continuous learning and improvement of the service had not taken place in line with the provider's improvement plan and reviews.

We found the lack of effective monitoring of the service and poor quality care and management records meant people did always receive a good standard of care. This was a breach of regulation 17 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The service did not do all that they could to meet people's equality characteristics. We found when people's cultural needs and wishes were recorded there was not always enough detail to provide appropriate support. On one occasion a person's main language was recorded on their assessment forms but did not clearly describe which version of the language was spoken. This person had specific communication needs but this lack of detail meant that staff might not have had all the necessary information to communicate with the person.
- The service did not always have sufficient details written in care plan to support people with learning disabilities or brain injury. We observed a person was upset and had displayed verbal aggression towards members of staff. Their care plan did not indicate what triggers would make them upset or a risk management plan to guide staff on how to support the person. Following the inspection the provider wrote to us and told us they had reviewed and updated the person's care plan.
- Staff meetings took place with care workers to share information with them about any changes that occurred in the service. Staff told us the team and management were supportive and they worked well together and were about to raise concerns with their manager.

We recommend the provider consider current guidance about effective person centred care planning.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered manager took action to gather feedback from people about the care and support they received. People had mixed views of the service and they told us, "This service is OK. I have nothing more to say", "Ok not good not bad. Staff are very well trained to look after me" and "[I am] delighted with the care he received but twice found a nurse asleep on night duty." We shared with the manager the feedback from staff sleeping on duty and they said they would look into this concern, but we have not been updated."
- All relatives we spoke with said they felt comfortable to contact the staff and manager to make a complaint and were confident they would be managed.
- Staff attended regular meetings to discuss any provider correspondence or concerns that occurred at the service. This meeting provided staff an opportunity to share ideas, have discussions and for staff to ask questions to senior staff.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The manager understood their responsibilities in relation to duty of candour.
- The manager told us that they knew they had a legal responsibility to share information with the local authority and the CQC when things go wrong.

Working in partnership with others

- Staff worked in partnership with colleagues from health and social care services so people could have access to consistent care and advice when required.
- Records showed that staff frequently contacted health and social care professionals for advice and support when people's needs had changed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure service users' risk assessments and risk management plans were effective to mitigate risks. The provider failed to ensure medicine management systems were robust. Regulation 12 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure effective monitoring of the service and properly maintained care and management records. 17 (1)

The enforcement action we took:

A warning notice was served, representations made by the provider and we reviewed them. A decision was made not to uphold the representations and to publish the warning notice.