Care Quality Commission

Bupa Care Homes (CFC Homes) Limited

# Premier Court Residential and Nursing Home

**Inspection report**

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

## Overall summary

This inspection was undertaken on 20 January 2015 and was unannounced. Our previous inspection was undertaken on 14 June 2013 where we found that all of the regulations were met.

Premier Court Residential and Nursing Home provides accommodation for up to 59 older people who require nursing care and may also live with dementia. At the time of our inspection 52 people lived at the home.

The service has experienced a period of instability in the local and regional management team which has had a negative impact on the quality of the service provided. There is a new manager in post who has submitted an application for registration at the time of this 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

# Summary of findings

persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

CQC is required to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection no applications had been made to the local authority in relation to people who lived at Premier Court Residential and Nursing Home.

The administration of medicines did not always promote the safety and well-being of people who used the service. Staff contacted healthcare professionals if they needed additional support. However, people's care plans did not always reflect their needs and risk assessments were not always in place.

Staff recruitment processes were safe and there were enough staff employed to meet the needs of people in the home. A range of training was provided to staff to give them the skills and knowledge required to undertake their roles. People told us that the staff were kind and caring. Care and support was delivered in a way that protected people's privacy, promoted their dignity and respected their wishes.

Although people's nutritional needs were met however, some people told us that they experienced varied mealtime experiences. People who chose to eat their meals in the communal dining room received appropriate support. However, people who chose to eat in their rooms said that food was frequently cold when it was delivered to them.

Personal care and support was delivered in a way that protected people's privacy, promoted their dignity and respected their wishes. However, the arrangements in place to store people's confidential information and medical histories were not effective.

The provision of activity and stimulation was appreciated by those people who were able to take part. However, activities had not been tailored to meet people's specific interests. The provider had arrangements in place to support people and their relatives to raise complaints or issues of concern and provide feedback about their experiences but these were not always effective.

Effective systems were not in place to assess, monitor and manage risks to people's health, safety and welfare. For example, the lack of effective medication audits resulted in potentially unsafe PRN practice and lack of effective care planning audits resulted in people being at potential risks of choking or developing pressure ulcers.

At this inspection we found the service to be in breach of Regulations 9 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond to regulations 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service is not safe.

People's care plans did not always reflect their needs and risk assessments were not always in place.

Medicines were not always managed safely for people and records had not been completed correctly.

Staff recruitment processes were safe and there were enough staff employed to meet the needs of people in the home.

There were suitable arrangements in place to safeguard people who lived at the home

**Is the service effective?**

Requires Improvement

The service is not always effective.

Staff contacted healthcare professionals if they needed additional support to meet people's needs.

People's nutritional needs were met but they had varied and inconsistent mealtime experiences.

A range of training was provided to staff. Staff said it gave them the skills and knowledge required to undertake their role effectively.

**Is the service caring?**

Requires Improvement

The service is not always caring.

People told us that the staff were kind and caring.

The arrangements in place to store people's confidential information and medical histories were not effective. This meant that people's confidentiality and dignity was not promoted.

Care and support was delivered in a way that protected people's privacy and promoted their dignity.

**Is the service responsive?**

Requires Improvement

The service is not always responsive.

The service failed to respond to people's identified needs because appropriate plans of care were not always put in place.

The provision of activity and stimulation was inconsistent and did not always meet people's needs.

# Summary of findings

The provider had arrangements in place to support people and their relatives to raise issues of concern and provide feedback. However, these were not always effective.

**Is the service well-led?**

**Requires Improvement**

The service is not always well-led.

There was a lack of robust risk management systems to protect people against inappropriate or unsafe care and support.

Staff spoke positively about the new manager at the home and said they were supportive of them.

# Premier Court Residential and Nursing 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 met 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 under the Care Act 2014.

This inspection took place on 20 January 2015 and was unannounced. The inspection team was formed of two inspectors and a specialist nursing advisor. The service was found to be meeting the required standards at the last inspection on 14 June 2013.

Before our inspection, the provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law.

During the inspection we observed staff support people who used the service, spoke with three care staff, three nursing staff, the manager, the deputy manager and the regional manager. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with family members to obtain their feedback on how people were supported to live their lives and received feedback from health care professionals and external stakeholders.

We reviewed care records relating to six people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and quality audits.

Inadequate

# Is the service safe?

## Our findings

People who needed their medication at specific times in order to manage conditions, such as Parkinson's disease for example, told us their needs were met. We observed that people were supported to take their medicines at their own pace and were not rushed.

We found that medicines were stored safely. However, we found that people who were prescribed medication on an 'as required' (PRN) basis to manage pain were not offered their medication at the prescribed intervals. There was no specific information available to guide staff about how people may express pain and therefore benefit from their PRN medication. People who were prescribed medication as a variable dose to manage pain did not always receive their medicines effectively. For example, directions for some medicines stated that one or two tablets could be taken up to four times a day but there were no instructions to explain when or in what circumstances. This meant that people may not have had their pain identified and managed appropriately or safely in all cases.

We found that some medicines had been signed for as being administered, but the tablets remained in the blister pack unopened. In other examples we saw that medicines had been given but had not been signed for appropriately. Topical MAR charts (TMAR) for the administration of prescribed creams were poorly completed with many gaps in recording which meant that people may not have received creams and ointments as prescribed. An external pharmacy had undertaken an audit of medicines held at the home on 14 January 2015 and had identified that stock balances did not tally with records. The audits undertaken on behalf of the provider had not identified these shortfalls which meant that people were at risk from unsafe medication management.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12(f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us they felt that staff did their best to look after people's care needs but that people were at risk from receiving poor care. For example, staff told us how they provided care and support for a person who had left sided weakness. However, there was no written guidance for staff to follow to ensure the person received their care safely. The risks to the person from incorrect moving and handling had not been assessed. Another example was where a person who was at risk of choking due to their medical condition received support from staff to eat and drink. A health professional had been consulted for advice and guidance. However, there was no specific guidance for staff to follow to ensure the person received their care safely and in a consistent manner to meet their needs. The absence of clear instruction for staff to follow meant that people may not always have received consistent and safe support.

A person who had been identified as being at high risk of developing pressure ulcers needed to have their position changed regularly. The person's care plan indicated that a position chart was in place to guide staff to regularly assist the person to re-position in order to protect their skin. However, despite speaking with staff it remained unclear as to whether this had been done which meant that the person may have been at risk of developing pressure sores.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9(3) (b)-(h) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014.

Relatives told us they felt that people were safe, one person said, "We are very happy with Premier Court. [Relative] receives good care from good staff. [Relative] is safe here." There were suitable arrangements in place to safeguard people who lived at the home which included reporting procedures and a whistleblowing process. Advice about how to report concerns was displayed and included contact details for the relevant local authority. The manager and staff team knew how to record and investigate safeguarding concerns appropriately.

People gave mixed views about whether their needs were met promptly. One person told us, "Staff do not always answer the [call] bell in a timely way. They are so busy. It is better at night than day time." However, another person said, "Every time I want something I ring the bell and they [staff] come and help me". Staff told us that the recruitment of new staff members and the introduction of the senior care role meant that they were able to meet people's needs in a timely manner. A relative told us that staffing levels had improved recently. We saw that call bells were answered in a timely fashion. This meant that there were sufficient numbers of staff available to meet people's needs.

Inadequate

# Is the service safe?

We found that safe and effective recruitment practices were followed to ensure that staff did not start work until satisfactory employment checks had been completed. This meant that people received their care from staff that were of good character, physically and mentally fit for the role and able to meet people's needs.

Requires Improvement

# Is the service effective?

## Our findings

People were looked after by staff who had the knowledge and skills necessary to provide safe and effective care and support. One person told us, "Staff seem to be really competent and capable." A relative said, "The staff certainly seem to know what they are doing." Staff members told us they received regular training updates which we confirmed during our inspection. New staff members were required to complete an induction programme and were not permitted to work unsupervised until assessed as competent in practice. Staff told us they were able to discuss any aspect of their role with seniors which made them feel supported and valued.

People told us that their consent was obtained before care was provided. One person said, "I rely on the staff for all my care needs. They always ask me what I want every inch of the way." The staff team and manager had received training to give them knowledge of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They demonstrated a good understanding and were able to explain how the requirements worked in practice. DoLS apply when people who lack capacity are restrained in their best interests to keep them safe. The manager told us that nobody who lived at the home was subject to a DoLS authorisation at the time of this inspection.

People told us that they enjoyed the food, one person said, "The food is very good. I can't grumble there. You get good choices and I particularly like the roast beef." We noted a kind and warm interaction between people and the staff members during the lunch service in the dining room. We saw that people were offered a choice of fruit juices, squash or water with their lunch. Staff members sat with people and assisted them to eat as necessary. We saw that staff monitored people closely to ensure they ate and drank well and maintained a healthy diet. For example, we saw that a person's weight had reduced and a referral had been made to a dietician and to the speech and language therapy team for advice and guidance.

However, some people who chose to eat meals in their rooms told us that food was often cold when it arrived. We saw that meals were delivered to people in their rooms on a trolley. This meant that the food was not always hot when they received it. We heard a person call from their room asking for help to eat their food because they were not able to raise themselves up in bed sufficiently to eat the meal provided. Staff did not respond to the person's calls. This meant that people did not always enjoy their food or receive the support they needed to eat their food.

People told us that they were supported to have regular health checks, for example eye tests, dentist and support from their GP. One person told us about physiotherapy support they received and how staff helped them with exercises to regain their mobility. Staff told us that they attended handovers at the start of each shift where they were given information and updates about people's changing health needs, which included GP and chiropody visits. This meant people could be confident that their routine health care needs had been reliably and consistently met.

Requires Improvement

# Is the service caring?

## Our findings

People gave us positive feedback about the care they received. One person said, "You read such horrendous stories about care homes but this is the complete and utter opposite." Another person told us, “Everyone is kind to me here. They wash me properly and they help me get out of bed when I want to.” Relatives were also positive about the way in which care and support was provided. One relative told us, “[Relative] is happy here, that is the most important thing to me.”

However, we noted that it was not warm in the home and people’s hands were cold to touch. A number of people told us that they felt cold; one person said they had given up trying to read their newspaper because their arms were cold outside their bed covers. One person had been struggling to put another layer of clothing on and was becoming distressed so we called for a staff member to assist. There was an acknowledged problem with the heating at the home but there were no plans in place to relieve people’s distress and discomfort. Staff members told us that they also felt cold however, they did not respond appropriately to alleviate people’s discomfort.

This was a further breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9(3)(b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People’s confidentiality and dignity was not always promoted. The arrangements in place to store people’s care records, which included confidential information and medical histories, were not effective. We found that the room used to store records was not always locked or secured and that personal and private information was left unattended on a desk in a communal area. This meant that people’s personal and private information was not stored in a manner that respected their dignity.

People told us that staff always knocked before entering their bedrooms and made sure that doors and curtains were closed when helping them with personal care. Relatives told us that they were able to visit people at any time without restrictions. We saw that staff knew and used people’s preferred names and worked at a pace that best suited their individual care and support needs. Care and support was delivered in a way that protected people’s privacy, promoted their dignity and respected their wishes.

People and their relatives told us that they were involved in planning of their care. The staff told us that they planned and organised people’s care with involvement from the person. Relatives told us that the staff at the home usually kept them informed of changes. Relatives told us that they were welcomed into the home and staff were friendly.

Care staff were knowledgeable about people’s individual needs and preferences in relation to their personal care needs. We saw that people and their relatives had been involved in discussions about the care provided. Staff told us they had handover meetings between shifts to ensure that everyone had up to date information in the event that people’s health needs changed. For example, staff were updated about people who had been unwell during the previous shift.

Requires Improvement

# Is the service responsive?

## Our findings

Health professionals provided us with mixed views about the quality of the healthcare support people received. For example, we were told that appropriate referrals were made for specialist treatment for people with Parkinson's Disease. However, we were also told that advice and guidance provided in relation to facilitating improvements in people's mobility was not always followed.

People may not have received safe and effective care that met their needs. This was because staff had not been provided with adequate information or guidance about the care and support required. For example, we found that people with diabetic care needs, people at risk of developing pressure ulcers and people with end of life care needs did not always have effective plans in place. We spoke with nursing staff who did not understand the importance of having plans in place to ensure that people received care based on their individual needs. This means we cannot be confident that people's health needs were met in all cases.

This was a further breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9(3)(b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that various activities took place in the communal lounge area for people who were able to take part. This included some games which generated much conversation and laughter. People who took part said that they enjoyed themselves and made positive comments about the activity co-ordinator. One person told us how they did not wish to be involved with group activities but said they were happy because, "I listen to the radio and have my newspaper." However, we found that people were not supported to follow their interests and take part in social activities specific to their individual needs. We found that care plans contained little information about people's social interests and preferences. For those people who were not able to communicate, staff told us that they had learned about people's preferences by trial and error and talking with relatives.

People who were able to speak with us said that they made choices about their lives and about the support they received. They said the staff in the home listened to them and respected the choices and decisions they made. One person told us, "I have had physio and have exercises to do. I need assistance to stand. I rely on staff to do everything for me. I'm given choice about all aspects. For example, what time I get up, go to bed, receive my personal care, or where to sit."

Arrangements were in place to support people and their relatives raise complaints, issues of concern and provide feedback about their experiences. These included a complaints policy and procedure, meetings for residents and their relatives and feedback survey questionnaires. The manager told us that there had not been any complaints raised with them since they had started at the home in October 2014. However, we found there was an acknowledged historical problem with the heating system at the home. We were told that this had been raised by relatives and staff but no actions had been taken to resolve the problem or relieve people's discomfort. This meant that the arrangements in place to respond to people's concerns were not always effective.

Requires Improvement

# Is the service well-led?

## Our findings

The manager was new in post having started in October 2014. We received many positive comments about the manager from staff who told us that they were both approachable and communicated well. A health care professional told us, "There seems to have been quite a turnover of management and this probably reflects throughout the home." Another person said that communication problems had been, "Exaggerated by the home having at least four managers and several temporary managers over the past 18 months." Staff told us that many positive changes had taken place since the new manager had started to work at the home which had reduced the pressure on the established staff team and reduced the use of agency staff.

People who lived at the service, their relatives and staff members told us that, due to a period of instability in the local and regional management team, some areas of leadership had suffered. These areas had included a lack of adequate staff supervision sessions and meetings with people who used the service and their relatives. However, we found that the manager had reinstated supervisions and staff told us that the system gave them a formal platform to raise any concerns and discuss personal development. Relatives told us that there had been a meeting held to introduce the new management team.

Although there were systems in place to assess the quality of the service provided in the home we found that these were not always effective. The systems had not ensured that people were protected against inappropriate or unsafe care and support. We found shortfalls in relation to medications, people's mealtime experiences and the risk assessment and planning of people's health care needs.

The provider had a quality assurance system in place to obtain the views of people who used the service, their relatives, staff members and external stakeholders. Questionnaires had been sent out in January 2015 and we were told that the manager would develop action plans to address any identified shortfalls in the service provision.

Relatives told us of previous concerns about staffing levels but said that this had improved recently. The customer satisfaction survey report from 2014 praised the warmth and friendliness of the staff team but identified low staffing levels. The manager told us that a successful recruitment campaign had taken place with two registered nurses and 11 care staff recently recruited.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br><br>We found that the registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving treatment of care that was inappropriate or unsafe.This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3) (b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br><br>We found that the registered person did not operate effective systems to protect service users from the risks associated with unsafe use and management of medicines.This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |