Astley Care Homes Limited

Uplands Nursing Home

Inspection report

43 Uplands Road
Selly Park
Birmingham
West Midlands
B29 7JS

Tel: 01214713816

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Ratings

Overall rating for this service	Requires Improvement
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Uplands Nursing Home provides accommodation with nursing for up to 27 people many of whom live with dementia. The home has a registered manager who was present throughout our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We carried out an unannounced comprehensive inspection of this service on 15 and 16 March 2016. At that inspection we found that the provider had not ensured that there were effective systems in place to monitor and improve the quality and safety of the service. We found that the registered provider was in breach of Regulation 17 of the Health and Social Care Act (2008) Regulations 2014, Good Governance. After that inspection the registered provider sent us an action plan detailing plans they had made to meet the legal requirements to have an effective system in place to monitor and improve the service.

We undertook this unannounced focussed inspection on 4 November 2016 to check if the provider had followed their plan with regards to the monitoring of the governance of the service. This report only covers our findings in relation to whether the service was 'Well Led'. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Uplands Nursing Home on our website at www.cqc.org.uk.

At this inspection we found that some improvements had been made and the home was no longer in breach of regulation.

The registered manager had improved systems to ensure all staff received the training they needed for their role and had improved their own knowledge of the regulations.

One relative told us that people had access to activities within the home. Opportunities people had for meaningful activities had been improved in the home although we found that the monitoring systems in place had failed to identify that not all people using the service had been provided with opportunities to engage in activities of interest to them. We had been informed that the registered provider had improved the systems for people to feedback their experiences of care. Relatives informed us that staff spoke with people daily to check on their well-being. However, we found that the system introduced had failed to identify that many people had not engaged in providing and sharing their views and feedback on the quality of the service.

Following our last comprehensive inspection we received information of concern from the local fire safety officers. We contacted the registered provider to gather evidence of what they were putting in place to meet these concerns. We looked at the action that had been taken as part of this inspection and found that there had been improvements made to the fire safety systems.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Improvements had been made to the quality monitoring systems. We found that further improvements were needed to ensure that the system was comprehensive.

Auditing systems in place had failed to identify that people had not been supported consistently under the Mental Capacity Act (2005).

The registered manager was aware of their responsibilities in respect of compliance with the regulations.

Uplands 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 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.

We undertook an unannounced focussed inspection of Uplands Nursing Home on 4 November 2016. This inspection was carried out to check that improvements planned by the registered provider to meet the legal requirements had been made following our inspection on 15 and 16 March 2016. We inspected the service against one of the five questions we ask about the service: is the service well-led?

This inspection was undertaken by one inspector.

As part of this inspection we reviewed information we held about the home, including notifications that had been sent to us.

At the inspection we spoke with the registered manager, an administrative assistant, one person, two relatives and three staff. We sampled records including quality monitoring systems, one care plan and information about training provided.

Requires Improvement

Is the service well-led?

Our findings

At out last inspection on 15 and 16 March 2016 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not have effective systems to monitor the quality and safety of the service. The registered manager had produced an action plan detailing their plans to improve this part of the service. At this inspection we found that some improvements had been made and the home was no longer in breach of Regulation 17. However we found that some of the new system improvements had not been fully effective and further work was needed to embed the systems and apply them across the service.

The provider had introduced systems to ensure that staff received the training they required to be able to support people appropriately. We found that these systems had improved the completion rate of staff carrying out training and most staff had received the training they required. We saw that although not all staff had attended all courses such as fire safety training, this training had been scheduled and following the inspection the registered manager informed us that the majority of staff had completed this training. The provider had improved the systems around training of staff which meant that people would benefit from staff who had received regular training and timely updates to ensure they worked safely and in ways consistent with best practice guidelines.

The registered manager had improved their knowledge of the new regulations in order to ensure people were receiving support that complied with the regulations. They were now aware of changes such as the duty of candour regulation and the registered manager was able to tell us how they would apply this to the provision of the service.

At our last inspection we found that the systems to identify if people had access to meaningful activities required improvement. At this inspection we found that some improvements had been made and other plans for improvement were in place. The system had not included consideration of activities for everyone. For example, the needs of people who remained in bed, due to healthcare conditions, to participate in activities of interest to them had not been identified or addressed. One relative we spoke with explained that their relative participated in activities and told us, "Staff do try and get her involved." Staff we spoke with informed us that the activities co-ordinator organised activities for people and told us about activities that took place such as reading newspapers with people and outside entertainers who came in to the home. The registered manager informed us about some of the improvements that had been made including the introduction of a sensory area at the home.

At our last inspection we found that systems in place to seek feedback about people's experiences of living at the home needed improving. We had been informed that the registered manager had introduced systems to gather feedback from people and their relatives as part of the providers plan to improve the quality of the service. We saw that this had not been fully addressed and the provider had not consistently sought feedback from people and their relatives. Many people would not have been able to feedback their experience of care through meetings due to healthcare conditions. However there had been no other systems introduced to seek people's feedback about their experience of care. Relatives told us that staff

spoke with people daily to check on their well-being. The registered manager explained that people were asked daily for their feedback about the service although this was not currently recorded.

As part of the provider's systems to gather feedback from people we saw that the provider had issued a survey for relatives. A small number of relatives had responded to the survey but there was no evidence to indicate what action had been taken where concerns were raised. We spoke with the registered manager about this who informed us that due to the low numbers of responses surveys would be sent out again to gather feedback about people's experiences of the service.

At our last inspection we found the systems in place to monitor whether people had their rights protected under the Mental Capacity Act 2005 (MCA) were not robust. At this inspection we found that there had been some improvements in MCA practice and the registered manager gave one example where a best interest meeting had taken place, in consultation with other significant people, where it was deemed that a person lacked capacity to make a specific decision. However this practice was not fully embedded into the culture of the service and we noted that the auditing systems in place had not identified that the mental capacity assessments for people were generalised and did not specify which decision the person couldn't make and needed to be helped with. The systems in place had failed to identify if people making other significant decisions had the legal authority to do so.

We looked at the systems to continuously monitor the service. The registered manager had a system in place to notify and share details of events in the home with the registered provider. Reports to the registered provider, from the register manager detailed key events that had occurred at the service and action that had been taken in relation to these. The registered manager was able to state action they had taken where concerns had arisen, although we saw that some of these audits did not clearly state what action had been taken or the monitoring systems that had been introduced where concerns had been identified. We saw that the audit systems in place had failed to identify that some care plans had not been completed fully.

Following our last inspection we had been contacted by the local fire safety officers who had carried out their own inspection of the service. At that time several concerns were found in relation to the safety of the premises and in the systems in place for fire evacuation. As a consequence the registered provider had developed a plan of how they would take action to address these concerns. At this inspection we found that the registered provider had made improvements to the safety of the premises and had sourced new equipment to support people in the event of a fire evacuation. We spoke with staff about what action they would take in the event of a fire and we found there was a lack of clarity amongst several staff about who would be responsible for calling for the emergency services, if needed. We spoke with the registered manager who assured us they would address this. Prior to this inspection we contacted the local fire safety officers who informed us that progress had been made in addressing the original concerns raised.