Bupa Care Homes (CFChomes) Limited

Thatcham Court Care Home

Inspection report

Chapel Street
Thatcham
Berkshire
RG18 4QL

Tel: 01635873834

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 4 and 6 May 2016. The inspection was unannounced on the first day and announced on the second day.

Thatcham Court is a detached modern purpose-built home situated in the centre of Thatcham in West Berkshire, close to local shops and other amenities. People have their own bedrooms and use of communal areas that includes an enclosed private garden. The people living in the home live with dementia and other health related conditions and need care and support from staff at all times. The service is registered to provide care and nursing care for up to sixty people. There were fifty-eight people in residence during our visit.

There is a registered manager running the service. 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. The registered manager was not available at the service, which is being managed by an interim manager with support from a deputy manager.

There were systems to regularly assess and monitor the quality of service that people received, but the registered manager had not used these effectively to ensure people's safety and well-being.

Staff had not received the refresher health and safety training they needed to promote people's safety. They had not been supported with their development needs until the recent deployment of an interim manager and recruitment of a deputy manager. People, their relatives and staff told us they felt listened to by these two managers, who had endeavoured to improve the overall safety and well-being of people, whilst supporting and developing the staff team.

People's care plans were not up to date to fully reflect their care needs and/or fully identify individual risks. For example, to promote falls prevention, people's skin viability and to support people who displayed behaviours that could cause distress or harm to themselves and/or others. Staff did not receive an effective handover to make sure they were fully aware of people's changing needs. These issues were being reviewed and improved by the interim manager and deputy manager during the two days of our visit. They recognised the need for further improvements. Staff were receiving support to change the ethos of the home to promote person-centred care and improve communications.

There were enough staff to meet people's needs. Further improvements were being made by the managers to make sure staff numbers promoted person centred care. However, until February 2016, staff absences were not fully covered by agency staff. This left staff short on the floor or having to work excessive hours. From this date the interim manager and deputy manager made sure there were enough staff to promote a safe service.

People's nutritional needs were met with meals that were appetising and cooked to meet individual needs. Staff treated people with respect and kindness and embraced the support they needed to improve the quality of services to promote person centred care. People were encouraged to live a fulfilled life with activities of their choosing and were supported to keep in contact with their families. However, people who remained in their room through choice or frailty were at risk of social isolation and further improvements were needed to make the environment more dementia friendly.

There were robust processes in place to monitor the safety of giving people their medicine. Recruitment and selection process helped to ensure staff of good character supported people. Staff knew how to recognise and report any concerns they had about the care and welfare of people to protect them from abuse.

The service had taken the necessary action to ensure they were working in a way that recognised and maintained people's rights. They understood the relevance of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and consent issues, which related to the people and their care.

There were various formal audits and quality monitoring visits by one of the organisations area managers. One of those visits identified concerns. They notified the Care Quality Commission and local authority of their findings and of actions, they had taken to promote the wellbeing and safety of people.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured staff received refresher fire safety training to be confident of their actions to promote people's safety should there be a fire within the home. You can see what action we told the provider to take at the back of the full version of the report.

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.

The provider had not ensured staff received fire safety training to protect people from harm should there be a fire.

There were sufficient staff, but they did not always have the relevant skills and support to keep people safe.

People were supported by staff of good character who knew how to protect them from abuse.

People received their medicine safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not always received the support and training they needed to support and meet people's individual needs and preferences.

Staff had not met regularly with their line manager for support to identify their learning and development needs and to discuss any concerns.

People had their freedom and rights respected. Staff acted within the law and protected people when they could not make a decision independently.

People were supported to eat a healthy diet. They were helped to see their GP and other health professionals to promote their health and well-being.

Is the service caring?

Good

The service was caring.

People benefitted from a staff team that was caring and respectful.

People's dignity and privacy were promoted and respected at all

times by staff and their independence was promoted as much as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's assessed needs were not fully recorded in their care plans to provide information for staff to support them in the way they wished. These were being reviewed to promote person centred care.

People who remained in their room through choice or frailty were at risk of social isolation.

Staff knew people well and responded quickly to their individual needs.

There was a system to manage complaints and people were given regular opportunities to raise concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager was not open and approachable and had not promoted a positive culture.

The interim manager and deputy manager were open and approachable and had made a difference to promote a positive culture within the home, which was on going.

Staff had confidence that they would be listened to by the interim manager and that action would be taken if they had a concern about the services provided.

There were audits completed to monitor the quality of the service and the running of the home. These included audits of health and safety and reviews of people's care and support plans.

Thatcham Court 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 the 4 and 6 May 2016. It was carried out by two inspectors and was unannounced.

Before the inspection the manager 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 looked at the PIR and at all the information we had collected about the service. This included previous inspection reports and information received from health and social care professionals. We also looked at notifications the service had sent us. A notification is information about important events, which the service is required to tell us about by law.

During our inspection, we observed care and support in communal areas of the home and used a method called 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 to us. We spoke with the area manager, interim manager, deputy manager, activity coordinator and six staff. We also received feedback from a local authority care quality officer and one health care professional.

We spoke with seven people and the families of five people. We looked at six people's records and records that were used by staff to monitor their care. In addition, we looked at six staff recruitment files. We also looked at staff training records, duty rosters, menus and records used to measure the quality of the services that included health and safety audits.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe in the home. One person said, "yes I feel very safe here". Comments from other people included, "yes we are very safe, I feel happy and calm. I don't feel worried" and "safe – oh definitely". Family members told us they were confident that their relative was safe in the home. They told us they had never seen anything they were not comfortable with. However, one person's relative told us that they did have concerns about whether there were sufficient staff. People were comfortable to approach staff throughout the day.

People were not fully protected against risks associated with fire. A fire risk assessment dated 20 May 2015, following a fire officer's visit had recommended fire safety training for staff. Additionally Thatcham Court's last fire evacuation drill on the 2 December 2015, identified that, "there was a lack of knowledge by staff who were unsure of the procedures" and had recommended further training. Despite the recommendations, over 64% of staff had not received fire safety training/refresher training. The interim manager told us that training had been difficult to book due to a shortage of trainers employed by the provider. We were informed that training dates had now been identified between 7 and 23 June 2016. The interim manager confirmed they would look at the dates against the staff rota to identify where staff could be released to undertake the training. Nevertheless at the time of our visit 12 months had passed since the initial recommendation by the fire officer. Staff had not received fire safety awareness training to be competent of the action they needed to take in the event of a fire. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities). This was because there was a potential risk for people's safety in the event of a fire.

People's care plans included assessments, which identified risks to the individual. The risk management plans were incorporated into the care plan. They were variable and whilst they identified risk, they did not always provide clear, detailed instructions of how to minimise the risks to the person. Examples included a risk of falls, which noted, "monitor regularly" but did not indicate how 'regularly'. An individual's falls diary noted as the action taken to minimise risk of recurrence, "offer them their walking frame". There was no reference to a review of the care plan or referral to the falls clinic or GP. The risk of people developing pressure sores was identified but it was not always noted at what intervals people needed to have their position changed.

People were protected against the risks of potential abuse. Staff were able to provide a robust response in relation to their understanding of safeguarding. They had received safeguarding training and where fully aware of the provider's whistleblowing policy. They also told us that if they had concerns and were not listened to by the registered manager or within their organisation, they would report their concerns to the local safeguarding authority or Care Quality Commission.

There were sufficient staff to meet people's basic care needs. However, staff told us that up until April 2016 there had been times when this was not the case. They gave examples of times when staffing dropped to two below the numbers of staff required. this was due to agency staff not been used to cover care assistant vacancies. We were informed that this had placed tremendous pressure on the staff team who worked extra hours in an effort to cover. Staff raised their concerns with the provider who had taken action. Staff said they

had seen improvements since highlighting their concerns as agency staff were now being used to cover staff shortages. A senior member of staff stated. "We are now using agency nurses and have block booked for 2016. Some staff who had worked overtime had been really tired". Adding, "Staff had felt they had no choice but to work the extra shifts to keep people safe."

There were 190 vacant care/senior care assistant hours each week. The interim manager told us that they had successfully recruited potential staff who were currently undergoing security checks to cover 168 hours. Other vacancies included housekeeping, administration and activities.

The provider had effective recruitment practices, which helped to ensure people, were supported by staff of good character. They completed Disclosure and Barring Service (DBS) checks to ensure that prospective employees did not have a criminal conviction that prevented them from working with vulnerable adults. References from previous employers had been requested and gaps in employment history were explained. The provider carried out checks to ensure people were being cared for by nurses who were registered on the Nursing and Midwifery Council register to practise in the UK.

People were given their medicines safely by staff who had received training in the safe management of medicines. The service used a monitored dosage system (MDS) to support people with their medicines safely. MDS meant that the pharmacy prepared each dose of medicine and sealed it into packs. The medication administration records (MARs) were accurate and showed that people had received the correct amount of medicine at the right times.

Staff used an observational pain assessment tool in the care of people who could not verbally communicate that they were experiencing pain. Staff told us that medicine prescribed for pain as and when required (PRN) was reviewed by the GP straight away depending on either the severity of the pain, or when a person had required the medication for more than twenty-four hours. People's medicine had the route to be given, such as oral or topical, detailed on the MAR.

Some people had guidelines for the use of any PRN medicines to support them with their behaviour. These contained enough detail to inform any staff when to administer them. However, of the three records we looked at one person did not have any guidelines in place. Covert administration of one person's medicine had been recommended in their best interest following an assessment under the Mental Capacity Act 2005 deprivation of liberty safeguards. An additional plan of care was approved by the persons GP to ensure they received the medicine they needed.

Requires Improvement

Is the service effective?

Our findings

People told us they were "well" or "properly" looked after. One person told us they could see a GP or nurse whenever they needed to. One person who was complaining about pain and a particular condition that was concerning them was immediately referred to the nurse on duty, during our visit.

People's needs were met by staff who had access to the training they needed. However, refresher moving and handling training was overdue for 36 staff. Dates had been identified to schedule staff attendance for this training but actual dates had not been confirmed for individual staff until the staff rota had been reviewed. One member of staff said, "I do not feel there is enough training support as training always coincides when we are short on the floor". Adding, "If you are on duty the day the training is provided, you come off the floor leaving the other staff short on the floor, and then you feel guilty." Three staff, which included the activity coordinator said they had not received dementia awareness training, although the activity coordinator told us that they hoped to attend a 'people first dementia second' course. The interim manager and deputy manager were reviewing staff training and confirmed that on-line courses (e learning) were being introduced to promote staff knowledge and development. However, staff told us that they were not confident in the use of e-learning and needed further guidance. We were informed by the interim manager and deputy manager that this was being arranged. Staff we spoke with either had a national vocational qualification or were working towards a diploma that was appropriate to their role.

Staff had not received regular one to one meetings with their line manager to support their development needs until the appointment of the interim manager. They told us that the interim manager had commenced staff appraisals and stated, "The climate we had worked in previously was very difficult and there were staff shortages." They said there had been a complete culture shift that had benefited people who use the service and staff. Additionally they stated that the interim and deputy managers were approachable and had an open door policy. One member of staff said, in reference of the interim manager, "We threatened to shoot her if she tries to leave."

Care plans included people's specific health and medication needs and records of healthcare appointments/outcomes. Nevertheless, their individual needs did not always cross-reference accurately. For example, one person's safety plan noted, "the person could walk independently with a stick" and their mobility plan said they were, "unable to move around". Another's behaviour assessment said, "unable to mobilise, nursed in bed". Whilst their wound care plan noted, "can weight bear and walk a few steps". On the day of the visit, they were sitting in a chair. However, staff had up-to-date knowledge of people's current needs and were able to explain how they supported them.

Some people who live in the service, displayed behaviours that could cause distress or harm to themselves or others, on occasion. There were some behaviour plans, of variable quality, in place. They were produced by the service and there was no evidence that other appropriate professionals were involved in their development. However, some people had been referred to psychiatric professionals and dementia specialists.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. Examples included referrals to the occupational therapist, dieticians and tissue viability nurses. We spoke with a visiting tissue viability nurse who told us that the staff were knowledgeable and were receptive to advice she had given on dressings to use. People had regular check-ups such as dentists and opticians appointments. It was clearly noted if people chose not to attend their appointments

People were encouraged to make as many decisions and choices as they could. Staff told us how they supported people to make choices for themselves. They gave examples of offering one of two alternatives. We saw staff were supporting people to make choices such as what activities they wanted to do, where they wanted to sit and what time they wished to get up. Experienced staff were advising less experienced staff how to offer choices and respect people's decisions.

The staff team understood and supported people's rights under the Mental Capacity Act 2005 (MCA). 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberties Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive people of their liberty were being met. The registered manager understood and followed the requirements in the DoLS. The service had made 35 DoLS applications, which had been authorised. DoLS were reviewed at the prescribed intervals and the paperwork was held on individual's records.

One staff member told us they had not received formal Mental capacity Act 2005 and DoLS training. However, they had a good understanding of what constituted a deprivation of liberty and when a DoLS referral may be necessary. They fully understood the principles of best interests and best interests meetings were held and recorded, as required. They included areas such as health interventions and covert administration of medicines.

People's nutritional needs were assessed by means of a nationally recognised assessment tool. Any individual nutritional requirements were included in their care plans. People were weighed regularly and records were kept, if necessary. The support of the dietitian was sought, as required. Photographs of different meals were used to help people make their food choices. Food was provided in the way which was safest for people to eat. This included soft diets and food cut into small portions for them. The dining experience was pleasant and calm. Staff gave people the amount of support they needed to finish their meals. People were able to take the amount of time they needed and preferred and could enjoy their food.

The environment was adequate to meet people's needs and all necessary mobility aids were provided. However, the home had long corridors with doors of the same colour, which could be confusing. A family member gave an example of their family member becoming confused and distressed because all corridors looked the same and they were unable to get to where they wanted to be. Visitors and new staff experienced the same difficulties. Some environmental enhancements had been made to make it more dementia friendly. For example, people had memory boxes on their doors but some areas needed further attention.

Good

Is the service caring?

Our findings

People told us, "I get looked after very well. They're most kind." "They're very helpful and kind staff." Two people said, "I'm very happy living in the home." A family member told us, "The girls are very kind and always cheerful." Another said, "They are kind and caring; nothing is too much trouble, which I know it is how it should be." On the day of the visit, staff were treating people with respect, patience and kindness. They used appropriate physical touch to calm and comfort distressed people. Staff used humour and positive comments to encourage people to be involved in daily routines and to increase their fluid intake. There was a calm atmosphere combined with laughter and singing.

People and their families were as involved in their care planning and reviews, as they were able to be and was appropriate. Families' involvement was noted and they sometimes signed care plans and other forms on people's behalf. It was clearly recorded that this was the preference of the individual or that relatives had acquired legal power of attorney (LPO) to make decisions about people's welfare. Staff advocated for people and challenged families or LPO's if they did not believe that decisions were made in people's best interests. Staff gave us a detailed example of this.

Staff told us and we saw that the permanent staff had developed strong relationships with people. They knew their wishes, preferences and how they expressed them. Staff behaviour and attitude showed that they cared about individuals and were committed to helping them to enjoy their lives, as much as possible.

Staff respected people; they maintained and promoted individual's privacy and dignity. Staff gave examples of how they did this. They told us they knocked on people's doors, encouraged them to close their curtains and ensured they were assisted with intimate care tasks by staff they were comfortable with. For example, care plans reflected people's preferences for same gender care and how their privacy was preserved. Throughout the visit staff assisted people with their personal care, discreetly. Examples included speaking as quietly as possible to ask people if they required help with personal care tasks and eating.

The service respected people's choices with regard to end of life care. An area of the care plan related to people's wishes with regard to the end of their life. This recorded where people wished to be if they became very ill and what they wanted to happen to them afterwards.

The service had notified us of 32 deaths. There were no concerns noted from the GP or coroner with regard to the type or number of deaths. Do not attempt cardio pulmonary resuscitation (DNACPR) instructions were in place for people, if appropriate. These had been signed by the GP and generally discussed with people, their families and care staff. One of the seven DNACPR's did not note whether it had been discussed with people or their families.

Requires Improvement

Is the service responsive?

Our findings

People were actively supported to maintain relationships with family and friends and keep in contact with anyone who was important to them. The service worked closely with families and kept them as involved in the person's care as was appropriate. However, some people were at risk of becoming socially isolated. The service had 60 staff hours allocated to co-ordinate and provide recreational activities for people. However, one of the two coordinators had left the service approximately one week prior to our visit, successful recruitment of the 30-hour post had taken place. People who use the service live with dementia; we found that at least 21 of those people remained in their room during the day through either choice or frailty. Therefore, it was imperative that they were provided with incentives of meaningful recreational activity to promote their mental health and wellbeing. The activity coordinator told us that there was "not enough time" to offer those people more than one meaningful 'one to one' activity session each month. Confirming that staff would "pop in to have a little chat or put the radio on". There were group activities provided and arrangements to have visiting entertainers throughout the year.

Staff responded quickly to people's needs and requests for attention or assistance. People told us staff, "were always there to help". However, handover meetings between staff at the start of each shift had not promoted a good exchange of information about people's changing needs. Care assistants, senior care assistants and registered nurse handovers were conducted separately. This had not promoted a responsive service. Staff told us if they had not been on duty for a few days, they were not always confident that they were up-to-date. They said that sometimes they telephoned colleagues at home to ensure they "knew what was going on". They gave an example of when they returned from leave and had not been made aware of someone's 'turning' needs. This had resulted in an individual being left for over five hours in one position rather than the two it should have been. A registered nurse said, "I like to come on shift early. I have a handover with the night staff and then I listen to the care assistant handover so that I know what is going on, on the floor". The deputy manager told us that they were in the process of reviewing staff handovers to make improvements.

People's needs were assessed before they moved in to the service. A relative said, "The service assessed (name) at hospital and when we came here we could not have asked for a nicer welcome". Care plans, developed from assessments, were reviewed monthly by senior staff, but sometimes were not altered in response to changing needs. Staff were informed verbally of any change to people's needs and responded appropriately. However, there was a risk that they would not receive all of the information they needed to be responsive.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. There had been six complaints since our last inspection and these had been investigated thoroughly and people and their relatives were satisfied with their responses. We saw staff listening to relatives and taking action to rectify their concern. The family of one person told us that they had raised some concerns about their relative's care that were listened to and action taken. They said, "It was reassuring as the actual care is brilliant".

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager at Thatcham Court who registered with the Care Quality Commission (CQC) on 11 May 2014, but was absent at the time of our visit to the service.

There were processes used by the provider to gain feedback from people on the quality of service received. These included the provider's complaint procedure and quality audits. These were completed by the registered manager, an area manager and quality manager at regional level to support the home and staff. Failings were noted in a quality audit in February 2016 which resulted in restructuring of the senior management. The area manager had notified the Care Quality Commission and local authority of their findings and of actions, they had taken to promote the wellbeing and safety of people.

There were other formal methods of quality monitoring that included unannounced spot checks at night by the area manager and interim home manager. Health and safety audits were completed and included infection control. Other safety checks included a fire risk assessment and fire evacuation drill that highlighted failings within staff training. Although failings were identified in May and December 2015, no action had been taken to secure fire safety awareness training for staff until May 2016.

A monthly quality matrix report completed by the manager measured the service across four key themes that included the quality of leadership and management. The audit looked at the impact the service had on people by measuring outcomes such as, the environment, equipment used, mortality, medication and pressure ulcers. However, the audit had not detailed whether there were sufficient staff and/or of outcomes from staff training and development. It was not until an area manager's quality audit of the service that the provider established low staff morale. This was due to insufficient staff, who had worked excessive hours and had not received the support they needed to promote the safety of people who use the service.

Staff told us that they had not been listened to by the registered manager when they voiced their concerns about staffing and the impact this had for the people who use the service. Comments from included, "We were upset because we felt we were giving baseline care to residents and that was not what we came into the industry to do." Therefore, due to no action taken when first highlighted, people experienced a service with low staff morale, a high ratio of staff sickness and staff resigning because they were unable to keep up with the demands made of them.

Staff said, "the home had been poorly managed, but now we have two managers who are making a difference" and "we now have agency cover until permanent staff are employed". However, staff reported feelings of low morale in the two weeks up to the date of our visit. Comments included, "perhaps after this inspection they (the provider) will sit up and listen" and "we know there are a lot of holes in the system (reference to paperwork) that we cannot prioritise". Staff said they recognised that improvements were needed. These included promoting the keyworker and named nurse procedure to ensure people's needs were reviewed, with changing needs fully identified and communicated to staff effectively.

Staff stated that despite the lack of support that they had received over the previous months they could see

improvements were being made. They told us they were confident that the interim manager and deputy manager would continue to drive through improvements that would have a positive impact for the people who use the service. Both of the managers were held in high esteem by a staff team who described them as open, approachable and supportive. The interim manager acknowledged that improvements were needed and stated, "We know there are areas that need to be improved. We are working hard with people their families and staff to make those improvements."

People and their families were able to express their views and told us they felt listened to. They felt confident that the interim manager and deputy manager would act in their best interest should they have a concern or complaint. Comments form a relative included, "I have to say the current management and staff looking after both (name) and us the family are being fantastic."

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 12 HSCA RA Regulations 2014 Safe care and treatment Staff had not received fire safety awareness training to be competent of the action they needed to take in the event of a fire.