Bupa Care Homes (CFHCare) Limited

West Ridings Residential and Nursing Home

Inspection report

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Overall summary

We carried out this inspection on 30 September and 2 October 2015. The inspection was unannounced. This was a focused inspection on the quality of care in the Kingsdale unit only.

The Kingsdale unit provides accommodation and nursing care for up to 28 people, who are in need of intermediate care and rehabilitation.

There was a registered manager in post for the whole site. However, upon our arrival we were told the site was being managed by a temporary manager and the registered manager had moved to another location. We had not been made aware of these changes. 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.

Staffing levels were not supportive of people's needs and people had to wait for assistance.

People told us that although staff were kind and caring, there were not enough staff to support them and help them feel safe.

There had been a high number of falls, some of which had resulted in serious injuries to people. There had been no management investigations into these incidents and no analysis or monitoring of accidents and incidents on the unit.

There were no individual risk assessments for staff to understand how to manage people's care safely, particularly with regard to moving and handling

Medications were not managed safely. People were prescribed and given medication that they were allergic to. There were errors in the recording of medication.

People's health care needs were not well managed. Staff had insufficient knowledge of people's treatment plans for wound care. There was no action taken when people showed signs of deteriorating health.

Staff's knowledge of people's needs was poor. Care documentation lacked detail and there was conflicting information in care plans.

There were ineffective processes for monitoring the quality of the provision and poor management oversight of people's care delivery.

Following the first day of our inspection we liaised with the provider and with Mid Yorkshire Hospitals NHS Trust,

Summary of findings

who gave assurances they would take immediate steps to improve patient safety on the Kingsdale unit. When we visited on day two, we saw there was a significant effort being made to address the concerns we had raised.

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?
The service was not safe.

People told us they did not feel safe and staffing levels were not supportive of people's needs.

There were no adequate risk assessments or care management plans in place.

Systems for managing medicines were not safe.

People's health care was not safely managed.

Is the service effective?
We did not inspect this domain at this inspection.

Is the service caring?
We did not inspect this domain at this inspection.

Is the service responsive?
We did not inspect this domain at this inspection.

Is the service well-led?
The service was not well led.

There was a lack of visible leadership in the service and lines of responsibility were not clear.

There were ineffective processes in place for clinical governance and auditing the quality of service provision and as a result, risks were not identified or managed.

Data management systems were poor and the quality and effectiveness of documentation was inadequate.

West Ridings 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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

This inspection took place on 30 September and 2 October 2015 and was unannounced. This was a focused inspection of the Kingsdale unit only, as we had received information of concern that the service was not safe or well managed.

The inspection was carried out by three adult social care inspectors and a specialist advisor, who specialised in falls prevention and risk management

Before the inspection we reviewed the information we held about the service. This included looking at any concerns we had received about the service and any statutory notifications we had received from the service.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with 10 people who were in receipt of care and two relatives. We also spoke with 12 members of staff, the clinical services manager, the acting manager and the area manager.

We looked in detail at 10 people's care records and observed care in the communal areas of the unit. We also looked at records relating to the management of the service. We looked round the building and saw people's bedrooms, bathrooms and communal areas.

Is the service safe?

Our findings

People told us they did not feel safe on the Kingsdale unit because there were not enough staff to support them. One person told us: "I've fallen before and that's why I'm in here. But there are no staff around and I'm scared I'll fall again so I just have to wait until they can help, but there's never any staff about". Another person said: "I've been here a month and it's always the same. The staff are wonderful, but they are so busy and we just have to wait until it's our turn and that can be a very long time. I would fall if I tried to move by myself" Another person said: "It's not right, the staff are so well meaning, but what can they do? If they're busy with other people, they can't be in two places at once". One person told us they were 'no better in here than struggling on my own'. They said: "I'm scared on my own and I'm scared in here. There's nobody to rely on".

When we saw staff were very kind and caring and when they assisted people, they made sure people had the support they needed to stay safe. However, we saw occasions when people repeatedly asked for help and staff were unable to assist because they were engaged in other tasks. One member of staff told us: "I always said I wouldn't be one of those staff that said 'two minutes' to people and didn't come back for ages. Now I find I'm saying it because I feel so bad telling someone I can't help them when they need it". Staff told us they tried their best to minimise the time people spent waiting for assistance with support, such as with going to the toilet. However, they told us, and we saw, people did have to wait, sometimes twenty minutes or half an hour for staff to support them. This meant people did not get the care they needed when they needed it.

Staff comments included: "There's a lack of staff to [take people to the toilet] on request and this is a concern", "Staff are run off their feet and a lot of the agency staff are thrown in at the deep end" and "The nursing staff don't seem to know the medical histories of the patients". Staff told us they felt personally upset because they cared about the people and wanted to do their job well, but low staffing levels meant they could not provide the care as people needed it.

We saw staffing levels were not at all supportive of people's needs and although staff worked continuously they were only able to carry out physical care tasks. Ancillary staff, such as hostesses were not always available and we saw this put additional pressure on the care staff. We heard call bells sounded frequently and although staff responded as quickly as they were able, there were delays in people being supported.

One person called to one of the inspectors to help: "Please can you help me? I need the commode, I can see it but I can't get to it. I've been waiting ages, no-one will help me." The inspector looked for a member of staff and asked them to help the person, but the staff member said they could not help immediately as the person needed two staff to assist and there was no help available. We saw the person waited a further 10 minutes before staff came to help. We spoke with the person later and they told us they felt embarrassed as sometimes by the time staff came it was 'too late'.

Other people's comments included: "It's worst at bedtime, when you just want to go to bed, it's awful. Staff are just so busy and you have to wait until they get to you. I'd even have the coalman help me when I get desperate. I'd have anybody when it gets so bad, that's how it feels" and "It's not nice to wait, especially when you need the toilet".

We observed a handover on day two of our inspection, from the night staff to the day staff. A member of the night staff interrupted the meeting to request one person be attended to first as they had been waiting a long time and night staff had not been able to support them. We saw this person was still in bed, very distressed and we heard them telling a member of the therapy team they had been 'waiting for hours' for assistance. We spoke with the night staff at the end of their shift and they told us one care assistant had gone off duty at 5am, leaving only an agency nurse and themselves a critical time when people needed support on waking. They said this meant some people had not had the support they needed.

We spoke with the agency nurse who was unable to tell us how many people were on the unit or the names of the nurses they had taken over from and handed over to. Furthermore, handover documentation they showed us was scant and insufficient and they were unable to tell us the dependency or mobility needs of any of the people on the unit. They told us one person needed two staff to help them move and transfer, but they could not tell us anything else about the person's moving and handling plan. This agency nurse was unable to show us any identification to verify who they were and there was no documentation to show the provider had made appropriate checks of their

Is the service safe?

suitability or competency. This meant there may have been staff working on the unit who did not have the relevant skills, knowledge or expertise to care for people appropriately.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 18 Staffing as there were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's needs.

Staff we spoke with told us they would be confident to report any concerns if they were worried about a person's well-being. Staff knew the signs of possible abuse and said they would always report to their manager, or to other relevant agencies if necessary. Staff said they understood the whistleblowing procedure for reporting poor practice if they witnessed this, to ensure people were safe. However, one member of staff said: "I don't think people would dare to whistleblow".

The Care Quality Commission had received notifications from the registered manager of safeguarding referrals they had made. However, there was sometimes a delay in reporting such incidents. This demonstrated that policies and procedures were not always followed for reporting safeguarding issues.

Accidents and incidents were not appropriately recorded or monitored to establish if trends or patterns occurred. Where we had been informed of people sustaining serious injuries, there had been no further investigations completed to establish root cause or identify future learning. There were no adequate risk assessments for people's individual safety or for the premises. Where errors in practice had been highlighted, no robust systems were put in place to prevent a reoccurrence. For example, we were told about an incident of poor moving and handling that had resulted in a serious injury to a person, yet a further member of staff had made a similar error.

The therapists used a walking aid labelling system (red, amber, green) which gave a quick visual indication of the mobility support required by each person. However, more detailed information about people's mobility support was not always known by staff on the Kingsdale unit.

We looked at the safety and suitability of the premises and some of the equipment. The environment generally appeared to be clean, tidy, and uncluttered. Staff told us they were not aware of any routine walk rounds or management checks to ensure the premises or equipment were safe. Although hoists were labelled to show when they had last been inspected and these were current, It was not clear if the unit had an effective system for the safe use, cleaning, and regular inspection of the slings which were used for the mobile hoists and staff gave differing accounts in this respect. There were a number of different slings stored in the bathroom which had no inspection labels and were not specifically allocated to any individual patient. Staff we spoke with said they were 'not sure' which people used which equipment. This meant people may have been at risk of injury from using unsuitable equipment or from unsafe moving and handling techniques.

One of the bathrooms was effectively out of action, as it was being used as an equipment store, with some mobility aids being stored in the bath. The other bathroom had a fixed bath hoist waiting for repair since 15 September 2015, which also meant that it was not available as a bathing resource.

Staff we spoke with confirmed there were currently no facilities available for people to have a bath should they wish to, although there were shower facilities available.

We saw the only shower chairs that were available were of the hard plastic type, one with castors, and one without. Neither had lap straps or any particular safety features to meet the differing needs of patients.

We saw a toilet hand rail in one of the shower rooms was insecure and its fixation points were loose. On day two of the inspection we also found a heavy ceramic cistern cover insecurely positioned on top of the toilet cistern. This appeared to be too large for the cistern and we raised concerns that this was a potential hazard, should it be pulled off by a person. Staff pointed out a toilet that was not secured to the floor and could easily be moved by pushing on it. We spoke with the clinical services manager about all of these hazards and asked that these be attended to with immediate effect. The clinical services manager requested attention to the faults and asked that a notice be placed on the bathroom door until the fault was rectified. However, by the end of the inspection on day 2 the room was not out of use and the fault had not been fixed. This meant that people were at risk from potential hazards, despite this being brought to the attention of management.

Is the service safe?

The unit was operating with two different record systems, therapy notes used by the NHS therapy staff and care plans by the unit itself. Although there were multi-disciplinary team (MDT) meetings held twice weekly it was not obvious how the discussion was being captured within the unit's care plans.

We saw a white board which the therapy staff used to record the mobility support required by each patient. This was covered by roller blinds to protect confidentiality of information as it was situated on a wall that could be observed through a window. The information was limited however, and most of the board was blank, which raised the question of the value of this information system. We saw this was not accurately maintained in respect of the people in the unit; not all people's names were recorded on the board and one person was recorded twice. Staff gave conflicting information about whether or how they used the information board.

There was no index in the care plans to indicate what documents should be in each plan, and no system to indicate which staff had read the plans. Inconsistencies in content could not be determined as being due to differing needs or omission errors.

The information contained within each care plan was rudimentary and appeared to rely heavily on one particular document 'My Day, My Life, My Short Stay Documentation'. Risk management was poor and information was scant and inconsistent. For example, when the 'falls risk' section for one person identified a high risk (a score of 13+) there was no further risk management plan to indicate how this would be managed.

Safe handling plans were also contained within the care file and again the information was rudimentary and sometimes inaccurate. For example, one person's plan contained only the words 'zimmer frame' under every section.

For one person whose record stated they were at 'high risk' of falls, there was conflicting information in their care plan which stated 'no risk' of falls. There was no robust system for recording the changing needs, or management of the significant risks for each person.

For one person who was clearly expressing significant pain there had been no pain assessment carried out for three days, yet staff told us this should be done daily for this person. This person had conflicting information in their care record about how their health needs should be met and staff were unable to confirm their plan of care. For example, they had dressings on both legs that were visibly stained. The nurse in charge said they should have their dressings changed daily, yet the record book for dressings showed these had not been changed for three days. Another nurse then said they were 'not due to be changed' and referred us to the person's care plan. This showed differing entries; that the dressings should be changed daily and twice weekly. However, the person's presentation of pain and the stained dressings did not trigger staff to take action. We saw from the person's notes they had been referred to the tissue viability nurse two days prior to our inspection, yet the nurse told us this had not been followed up.

We asked staff to attend to this person to relieve their pain and distress and staff came to assist. However, staff did not handle this person with care and this resulted in further pain. We saw there was no care plan in place for staff to understand how to manage this person's needs. We referred this person to the local safeguarding authority and discussed this with managers at feedback.

We saw from one person's care records their pulse had been recorded as very low. The person was noted to have a health condition that meant the low pulse may indicate a deterioration in their health and should have triggered further action by the nursing staff. However, it was not evident any further action had been taken We raised this concern with the clinical services manager, who agreed this concern should have been acted upon.

We saw people's blood sugar should have been routinely recorded and there were gaps in the recording. Where people were identified as needing to be weighed weekly, this was not recorded and staff could not confirm whether this had been done.

Staff we spoke with told us what they would do in the event of an emergency, such as if a person fell or if there was a fire. However, on day two of our visit four out of five staff, including the nurses in charge on the Kingsdale unit, were unable to tell us accurately how many people were being cared for. This meant that should there have been a fire or an emergency, people could not all be accounted for and people's safety could not be assured.

We looked at the systems that were in place for the receipt, storage and administration of medicines. We found

Is the service safe?

medication was not always administered safely. For example, people whose documentation showed they had allergies to certain medication had been prescribed and given that medication and there had been no checks made to identify such errors. Where one person needed a particular medicine, their pulse should have been taken prior to being given the medication to ensure it was safe to administer, yet it was not evident that this had been done and staff were unable to confirm. Where people were given laxative medication, there was no monitoring of their health needs in relation to this. Although the nurses giving medication wore red aprons to indicate they should not be disturbed during medication rounds, we saw they were frequently interrupted due to the demands of people on the unit.

There were gaps and errors in the Medication Administration Records (MAR). We saw there were codes numbered one to four for staff to use when drugs were not administered, to annotate the reasons why. However, we noted the codes were not recorded in some cases when there was no signature to show the medication had been given. Staff had also used additional numbers in some records, with no key code as to what the number meant. We spoke with the nurse on duty who told us they did not know what the additional numbers meant. The clinical services manager could not explain the other numbers used. We saw there were many records showing times when medication had been administered, but these were not signed by staff.

We spoke with one nurse who was responsible for giving medication but who was new to the unit. They told us they would check each person's identification and refer to their photograph on the record. We noted that some people's photographs were on their medication records, yet on at least four MARs we saw, there were no photographs to assist unfamiliar staff with identifying people.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12 Safe Care and treatment as care was not provided safely for people on the Kingsdale unit.

Is the service effective?

Our findings

We did not inspect this domain at this inspection.

Is the service caring?

Our findings

We did not inspect this domain at this inspection.

Is the service responsive?

Our findings

We did not inspect this domain at this inspection.

Is the service well-led?

Our findings

There was a registered manager in post for the whole site. However, upon our arrival we were told the site was being managed by a temporary manager and the registered manager had moved to another location. We had not been made aware of these changes. The temporary manager had only been in post for three weeks and had not been present for all of these three weeks.

People and visitors we spoke with did not feel the service was well managed and they did not feel well informed or included in their care or the care of their relatives. One visitor told us "I've asked 3 times for [my family member's] hearing aid batteries to be replaced but they've still not been done…it's a poor response". Another visitor said: "[My relative] has fallen three times but [staff] don't seem to know why". Another visitor said "We do not know what the plans are, but we come a long way to visit each week".

There was a significant lack of visible leadership in the Kingsdale unit and staff were not clear about their responsibilities. The house manager was on leave and staff gave differing accounts of who was in charge of the day to day running of the unit. The nurse on duty told us "I suppose it might be me who's responsible". Care staff said they would refer to the nurse as being in charge in the event of the house manager being unavailable. Some staff told us the clinical services manager was in charge of the unit if the house manager was not present.

The nurse in charge knew how many staff were on the rota but was unable to give the names of the agency nurse or the care assistants on duty and checked their identity badges before confirming to us who was working on the unit. We were told there was 'one care assistant short' but there was no plan in place for their replacement. Staff rotas identified that on many occasions there had been insufficient staffing on the unit due to staff covering on other units, yet there had been no monitoring of this carried out by managers.

The therapists reported having an open referral system and being able to see anyone admitted to the unit. Staff working on Kingsdale unit reported disjointed working arrangements between therapy staff and themselves and described it as 'them and us'.

Staff reported feeling undervalued and said they were 'not sure if there's a lack of interest or low morale'. Other staff reported low morale throughout the location and especially on the Kingsdale unit and said they did not feel well informed about the people they were caring for. One member of staff said "It can be difficult to keep up with things, I was only off for two days and when I came back there were four new people (patients)"

Some of the administration functions within the unit were organised well. For example, the unit administrator kept a discharge planning book to keep up to date with the discharge arrangements for each patient.

Therapy staff told us the nursing staff had access to the therapy notes when the therapists were not in the unit, these were transferred to the office. However, when we spoke with one nurse they were not aware they could access therapy notes and said they relied upon their own documentation in people's care plans.

Documentation to illustrate care management was extremely poor and not fit for purpose. For example, we saw intentional rounds forms that were meant to be completed when regular checks of each person were carried out. These forms were illegible due to repeated photocopying and yet they had been ticked by nursing staff against each of the headings when it was not possible to see what was being checked. Handover documentation and people's individual care documentation was scant and did not provide staff with sufficient or accurate information to be able to provide safe care.

We saw therapists employed a document audit tool and regularly audited their records. However, the provider had no robust audits in place, even though we were told the clinical services manager held responsibility for these.

We spoke with the clinical services manager who told us they were 'waiting for medication audits guidance to come from the trust' and none had been carried out recently by the provider for the Kingsdale unit. We saw some evidence that care plan audits were recorded as having been done. Where these had been marked as having errors or omissions, action plans to show what needed to be done were attached with the person responsible identified as 'RGN' (the nurse). There were no reviews to show what actions had been taken, when and by whom, yet they had been countersigned by the clinical services manager on some occasions, and not signed on other occasions. When we asked the clinical services manager to explain how the

Is the service well-led?

care plans were audited, they told us these were not robustly audited or reviewed. Our inspection findings showed care plans contained many errors and omissions that were not identified through a rigorous audit process.

We asked to see how the provider checked and monitored the qualifications, eligibility and suitability of agency staff. The acting manager confirmed that no checks were made, other than to assume the agencies had carried out suitability checks. We saw a 'new agency nurse safety checklist' for some of the agency staff that had been deployed, but this was a tick-list to show they had been informed of policies and procedures in the unit. We saw the form requested the person in charge checked identification of agency staff, yet this was blank. We asked to see forms for two agency nurses we knew had worked on the Kingsdale unit, yet no documentation was available.

There was no management oversight of practise on the Kingsdale unit. We saw some documentary evidence that clinical review meetings and daily review meetings were held and some of these were recorded, yet there was no consecutive ordering of the forms and the last recorded meeting was 10 September 2015. Managers were unable to confirm whether meetings had been held daily.

We looked at how accidents and incidents were reported and classified and analysed to identify trends and patterns. We spoke with the clinical services manager who told us they reviewed each accident and incident form from the Kingsdale unit and where it was deemed to be serious, this was inputted onto the service computer system for further analysis by the organisation. However, they were unable to tell us the criteria for what constituted a 'serious' accident/ incident . There was no information available to summarise incidents of risk on the unit and what was being done about this. Of particular concern was that we had been given information prior to the inspection of two serious injuries to people on the Kingsdale unit, yet the acting manager confirmed no root cause analysis or investigation into these incidents had been carried out.

The above examples illustrate that the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 17 Good governance as there were ineffective systems and processes in place to ensure the quality and safety of the service provided.