Care Quality Commission

Bupa Care Homes (HH Leeds) Limited

Sunnyview House

Inspection report

Manorfield
off Beeston Road
Leeds
West Yorkshire
LS11 8QB

Tel: 01132777160
Website: www.bupa.com

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Ratings

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

Summary of findings

Overall summary

This inspection took place on 28 February and 8 March 2018 and was unannounced. At the last inspection in January 2016 we found that the service was good.

Sunnyview House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates up to 84 people across three separate units, each of which have separate adapted facilities. One of the units specialises in providing care to people living with dementia, another provides care to people requiring nursing care, and the third was designed for people requiring residential care.

The service did not have a registered manager in post. It is a condition of a service's registration with CQC that there is a registered manager. The service had appointed a manager in December 2017 who was in the process of registering with CQC at the time of the 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.

People and relatives of people using the service we spoke with told us they felt the service was a safe environment. Staff were trained in safeguarding vulnerable adults and there was a robust safeguarding process in place.

Staff and people told us staffing levels were improving, and there were enough staff to care for people safely. Staff were recruited following robust recruitment processes.

Medicines were managed safely, and people were happy with the way they received their medicines.

The premises and estate was well maintained and clean. There were measures in place to prevent the spread of infection.

The service conducted mental capacity assessments and best interest decisions, however on one unit we found that practice was not always in line with the principles of the Mental Capacity Act (2005). We have made a recommendation about the management of mental capacity assessments and best interests decisions.

People were supported to maintain a healthy lifestyle and their health was monitored with tools recommended in line with national guidelines. The service was proactive in accessing healthcare professionals on behalf of people using the service.

People and their relatives told us staff were caring and compassionate. Staff knew how to protect people's dignity and privacy, and helped people maintain their independence.

There were not enough resources in place to provide people with meaningful activities and stimulation which took into account their interests. We have made a recommendation around the provision of activities.

People's care was planned in a person centred way and people were confident they knew how to raise a complaint.

The new manager had made improvements to the service with support from the provider. There was a quality monitoring system in place, and there was evidence this had been used to improve the service. Staff told us morale had improved and that they would recommend the service as a place to work and receive care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

Medicines were managed and administered safely. People told us they felt safe living at the service.

There were enough staff to deliver care, and staff were recruited in a safe way.

Staff received training in safeguarding vulnerable adults and there was a safeguarding process in place.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was not always operating under the principles of the Mental Capacity Act (2005).

Staff felt well supported through induction, training and supervision.

People were supported to maintain a healthy balanced diet and were supported to access healthcare professionals where necessary.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were caring, kind and compassionate.

People were supported to maintain their independence with help from staff who were attentive to their needs.

People's privacy and dignity was upheld by staff.

Is the service responsive?

Requires Improvement

The service was not responsive.

The service did not have the resources or structure to provide people with meaningful engagement that took into account their interests.

There was a complaints process in place and people were confident they knew how to raise a complaint.

People's needs were appropriately assessed before receiving care and care plans were written in a person centred way.

Is the service well-led?

Good

The service was not well-led.

There was no registered manager in post, however the service had appointed a manager who was in the process of registering with CQC.

Quality monitoring systems and processes were in place. These had not been used effectively under previous leadership, however the new manager was well supported and engaged fully with quality monitoring and improvement.

Staff morale had improved since the new manager took up their post and staff felt confident in the leadership of the service.

Care Quality Commission

Sunnyview House

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 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 28 February and 8 March 2018 and was unannounced. The inspection team consisted of one adult social care inspector and a specialist advisor with a background in pharmaceutical practice.

Prior to the inspection we gathered and reviewed information relevant to the service, such as notifications from the service, feedback from staff and people who use the service, and information sent by the provider in a provider information return (PIR). The PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we conducted a tour of the premises, and 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 to us. We interviewed seven members of staff, including the manager, unit managers, senior carer, registered nurse, maintenance staff and care staff. We also spoke with four people who used the service and five relatives of people who used the service

We also reviewed documents relevant to 11 people's care, such as their care plans, risk assessments, medicines records and nutrition charts. We looked at documents relating to the management and oversight of the service, such as audits, recruitment records, stock checks and staff meeting minutes.

Good

Is the service safe?

Our findings

People and their relatives told us the home was a safe environment. One person said, "It's all nice, there are no problems, staff are friendly and I feel safe here." A relative we spoke with said, "[My relative] is safe now, we feel she is looked after well."

We reviewed staffing levels. At the time of the inspection, staffing levels were safe. There were enough staff to deliver care, and where agency staff were used to fill staffing vacancies and maternity leave, they were regular agency staff known to people. People and staff told us that previously, especially during late 2017, staffing levels had been an area of concern. One staff member said, "We were using lots of agency staff leading up to Christmas last year. We had a few people leave, and lots of staff on maternity, but we are getting there and we have enough staff now to cope." Another member of staff said, "We used a lot of agency staff in the past few months but we are getting a lot more regular staff now. We always had enough staff to deliver care." One relative we spoke with said, "Staffing is now better. There are still agency staff but they use the same ones. We don't have to wait for a buzzer to be answered."

The service used a dependency tool to calculate the amount of staff required to deliver care. In response to changes in management and leadership at the service, the provider was supporting the service by maintaining staffing levels above the dependency tool calculation.

Staff were recruited safely. We reviewed five staff files and found that appropriate background and photo identification checks were carried out. These included proof of a valid DBS (Disclosure and Barring Service) certificate. The DBS is a national agency which uses the police national database to help employers to make safer recruitment decisions by checking new staff are suitable to work with vulnerable people.

We reviewed systems and processes around medicines administration and found that they were safe. The medicines policy was in date and clearly defined responsibility for medicines. We reviewed medicine administration records (MARs) on each unit and found medicines were recorded accurately and clearly. Medicines were stored safely. This included controlled drugs and temperature sensitive drugs which required refrigeration. The controlled drug log book and fridge temperature log book on each floor were regularly updated and signed. We found one person was having their medicines administered covertly (without their knowledge) and we observed the correct documentation was in place to evidence this was in their best interests and in line with the Mental Capacity Act 2005.

We observed people being supported to receive their medicines and found that staff gained consent and delivered medicines sensitively. People told us they were satisfied with the way their medicines were administered by staff.

Staff had been trained in safeguarding vulnerable adults. There was a safeguarding process in place and staff were confident about how to identify and raise concerns. One staff member said, "It could be a range of things, if somebody had unexplained bruising, or if they had a big appetite and suddenly lost it without explanation. I would go to the senior staff or manager. There is also a whistleblowing line [for anonymous

concerns]."

The service recorded all accidents and incidents, and carried out investigations appropriately. We saw that they were analysed by the provider and guidance offered to mitigate their impact. Individual risks to people were assessed appropriately with guidance for staff on how to minimise these and what measures were in place. These included risk assessments for contractures, falls and skin tears. Risk assessments included up to date national guidance and details of any contact with health professionals, such as the falls team and district nurse.

We reviewed records relevant to the safe maintenance of the premises and estate. Gas and electric safety certificates were present and in date. Checks to water temperatures had been carried out and water sources had been assessed by an external accredited agency to mitigate the risk of legionella bacteria entering the water supply. All equipment such as hoists and wheelchairs were regularly inspected. There was a fire safety risk assessment which had been carried out by an external specialist agency and each person had an individual personal emergency evacuation plan in their care plan to facilitate the safe evacuation of the building. There were regular fire drills and checks of systems such as fire extinguishers, lighting and exits.

The environment was visibly clean and tidy with no malodours. We observed staff using personal protective equipment (PPE), such as disposable gloves, when carrying out tasks such as personal care, medicines administration and food service. All sluice areas were clean and inaccessible to the public, as well as areas containing hazardous cleaning materials. Staff had been trained in infection prevention. Staff were knowledgeable about antimicrobial drugs such as antibiotics which prevent and treat infections.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that while some practice was good, there were other areas where the service was inconsistent.

On the dementia unit, capacity assessments were carried out and best interest decisions were made with consultation from appropriate stakeholders such as family members, social workers and other health professionals. All decisions made had been recorded clearly, signed and dated. However, on the nursing unit, we found some documents which were not completed to the required standard. For example, one person had a DoLS application submitted but there was no evidence of a mental capacity assessment being carried out. Two other people had best interest decisions made yet there was no evidence of other parties involved in the discussion and they had not been signed or dated.

Staff received training in the area of mental capacity and staff we spoke with were knowledgeable about the basic principles of the Act. One member of staff said, "It's about assuming someone has capacity until they are assessed as otherwise. It is put in place to assist someone make a decision. Our unit manager is really good with stuff like that." Another member of staff said, "We always assume they have capacity. Once I finish an assessment I write a best interests decision to say for example they wish to be safe and happy, we include other people in the discussion and I make a statement to say they'll live here."

We saw that the service had audited some of its own documentation on the nursing unit and had also identified (and corrected) a file where a mental capacity assessment had not been completed but a DoLS authorisation had been applied for. We raised these issues with the manager. They told us that a unit manager had been recently appointed to drive improvement on this floor and the manager was confident that these issues would no longer reoccur. They also told us they would revisit every DoLS application made and either withdraw or reapply with appropriate documentation in place.

We recommend the service continue to review and improve the consistency of its implementation of the principles of the MCA.

People and their relatives told us they felt that staff were well trained to support people adequately. One

relative said, "They are very well trained, they have been supportive for me. I didn't know about dementia but they give me support and advice." Staff told us they were well supported through training and induction. There was a programme of training the provider considered to be mandatory, such as safeguarding vulnerable adults, basic first aid and moving and handling people safely. The service used a training matrix to track which staff were due to refresh any training. One member of staff said, "We get sent email reminders for when we need to do mandatory training." We saw that where staff partook in specialised areas of practice such as medicines administration, they were assessed against a set of competencies and this was regularly reviewed.

Staff received monthly supervisions, where they discussed performance and support. One staff member remarked, "I find them useful; I like a challenge. It's nice to get a bit of feedback from managers and you get your chance to put across your opinion." Under previous management annual appraisals had not been carried out however the manager assured us they planned to conduct annual appraisals for all members of staff.

People were supported to eat and drink enough to maintain a balanced diet and healthy lifestyle. We saw that people's weight was monitored monthly, and where there were any concerns about unplanned weight loss, people were weighed weekly. The service used tools such as MUST (malnutrition universal screening tool) and the Bristol stool chart, which are recognised as good practice to monitor people's health.

We observed a mealtime and saw that there were up to date menus available which gave people a choice of dish for each course. Staff plated each option and presented them to people, to assist people in making their decision. People's preferences and choices were taken into account and this was recorded in people's care plans. One relative told us how their loved one was particular about certain ingredients and that the chef agreed to design a specific menu for them where these ingredients were absent. Staff were knowledgeable about different dietary requirements such as diabetic, fork mashable and pureed diets.

People were appropriately supported to access health professionals. We saw that each person had a record of preferred health contacts such as a G.P, and a log of all visits made to or by health professionals. Staff were proactive in seeking medical advice or calling ambulance services in the event of an accident or an observed deterioration in someone's health, for example a pressure ulcer. One relative we spoke with said, "They are really communicative about [my relative]'s health. The doctor comes every week and they arrange appointments for them. When they were concerned about her they told us they had called an ambulance."

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind and compassionate. One relative said, "They are like a family. One carer brought her baby in to see my mum and it cheered her up no end!" Another relative said, "I've got no problems with staff, they are caring and attentive. They are lovely."

During our observations we saw that people were visibly relaxed and people were able to have a laugh and chat with staff. Staff interacted with people patiently and discreetly. During lunch we saw staff getting down to eye level and speaking to people in a friendly way, and there was a pleasant and friendly atmosphere. We heard one person mention to their friend during lunch that they liked that staff were very friendly.

People were clean and well presented. One relative said, "People here always look nice, clean and maintained." One staff member described how they helped people look the way they wanted to, saying, "A lady I look after loves anything sparkly, the more sparkles the better! I help her put on her make up and put rollers in her hair."

Staff supported people to maintain their independence. We asked staff how they did this. One staff member said, "For example, when helping someone wash, we ask if they would like to do their own face and areas they can do for themselves. We help people to be as mobile as they can through gentle encouragement, and we also encourage people to make their own choices of food and clothes." Care plans were written in a way that encouraged independence, for example in each care plan (this could be for mobility, washing and dressing, and going to the bathroom) the plans started with a section called 'things I can do for myself', before the next section which detailed how the person wanted staff to support them.

Staff supported people to maintain their privacy and dignity. We observed staff knocking on doors before entering and asking people before they helped them with tasks such as moving or eating. One member of staff said, "We always make sure they are in a private area, seek consent before doing anything, ensure privacy is maintained and dignity maintained and by all means if they want you to leave then we leave. We have a lot of residents who require assistance and staff always seek consent." A relative said, "They never ask me questions for my [relative] when I'm here, they always ask her first and involve her in the discussion."

The service provided information on how to access an advocate. An advocate is someone that helps a vulnerable person to make decisions and express their views. This information was available in communal areas. We saw that documentation such as best interests decisions included advocates as participating members.

Requires Improvement

Is the service responsive?

Our findings

Although there was a weekly activities programme, there were not enough resources in place to provide people with meaningful and stimulating activities that took into account their interests. There was only one member of staff who was a dedicated activities coordinator responsible for devising and delivering activities and they did not work full time, and not at all on weekends. This meant that care staff were responsible for delivering activities on an ad-hoc basis. Care staff were not trained in providing activities.

During our inspection we reviewed the activities in place for the week, and there were one or two activities planned each day. On three of these days, 'table top board games' was an activity, and on Sunday it was listed that 'Sunday lunch' was an activity. There was no specific guidance available for providing these activities and no rationale behind them. One relative we spoke with said, "For people with dementia they had on the activities sheet that it was board games, but they don't have anyone to engage with them. We were told there would be 1:1 dementia specific activities. I've no problem with staff, they are caring and attentive but there is a lack of stimulation." One person said that although they had no issues with staff attitude or care, "They don't take us anywhere, it would be lovely."

We reviewed people's activities logs and found that they were not filled in regularly and did not evidence that people were engaged with or regularly offered to partake in activities and events. For example, in one person's record over a month there were four records in the log which included watching TV and reading the paper. In the 11 care plans we reviewed the activities logs consistently did not demonstrate that people had regular engagement with others, or that the opportunity had been offered.

We recommend the service review and improve the opportunities available for people to maintain active social lives and partake in activities relevant to their interests.

There was some evidence that the service had been trying to improve social engagement and facilities with people and encourage them to partake in activities. For example, they had converted an area into a resident and relative café, which was a protected area. Staff were discouraged from using the facilities unless there were specific safety reasons so people could have privacy. It was pleasantly decorated with plenty of drinks and fresh snacks available, a TV and pool table. People and relatives we spoke with agreed this was a positive change. One relative we spoke with told us how when they took their mum to the café they felt like they had been on a trip out and it had improved their day. One staff member said, "Activities could improve and we are improving activities and stimulation on the dementia unit. I know the manager is meeting a dementia interior designer to create interactive rooms as this is somewhere we can improve." A relative we spoke with said, "They've appointed a new unit manager and they are definitely trying to find out people's personal quirks and interests."

People were assessed appropriately before admission to ascertain their needs and make sure the service was able to meet them. This included questions around people's medical history, mobility, family networks and religious or cultural needs. This information was used to help create a more detailed care plan, which gave staff the information they needed to provide responsive care.

People and their relatives were involved in writing their care plans. One relative said, "We had a plan sent to us and they asked [my relative] what she liked and all sorts of things. They know how she likes things done." Care plans were detailed and person centred. For example, in one person's communication care plan staff were instructed to 'Make sure [Name] is alert, give him time to respond to any questions, offer him visual information'. Care plans also included people's life histories, including the place they grew up, their childhood friends and any holidays or pets that were important to them in their lives.

Care plans were regularly reviewed; on a monthly basis or in response to a change in circumstances such as a decline in weight or mobility.

There was a complaints process in place. People and their relatives told us they were confident they could approach the service with their complaint and that it would be responded to appropriately. We saw that the service followed its complaints policy appropriately when responding to concerns.

The service provided care for people at the end of their lives. One senior member of staff said, "We all have mandatory training on end of life care and we get advice from clinicians, from district nurses for syringe drivers for example." We observed during our inspection that a person returned from hospital and an end of life care plan was written which replaced other care plans and focused on their wishes for comfort and safety in a sensitive way. It contained detailed information about their religious, cultural and social wishes.

Good

Is the service well-led?

Our findings

The service did not have a registered manager at the time of the inspection. The service had employed a manager who had been in post since December 2017, however they were in the process of registering with CQC. The previous manager had not registered with CQC, which meant the service had been without a registered manager for over six months. We asked the service to provide evidence of their efforts to recruit a registered manager prior to our inspection, and found the service was making adequate efforts to do so.

Since our last inspection, we saw that quality monitoring processes were not always followed. For example, monthly metrics, which the service used to analyse and feedback on areas of improvement such as safeguarding alerts, accidents and falls data were not always submitted to the provider in 2017. We also saw that staff who were eligible for an annual appraisal did not receive one in 2017. Under current leadership, we saw these metrics were updated and analysed by the provider to identify trends and themes, and we saw that actions were undertaken by the manager to improve the service.

The provider had identified through its internal quality inspection (which adopted principles based on CQC's framework) that the service was in need of support and had sent a team of senior staff to assist the manager in making improvements. They had created a home improvement plan with named staff responsible and dates for actions to be completed. This included the completion of data for the provider and carrying out audits. The provider had also ensured that staffing levels did not fall despite a reduction in the number of residents. The manager told us they felt well supported to drive improvement at the service.

We reviewed other quality monitoring processes for their effectiveness at identifying and improving aspects of the service. There was a programme of audits, including check on MARs, daily care notes and maintenance logs. Senior staff from the provider's improvement team helped carry out audits independently to ensure processes were followed correctly. We saw that these identified issues and resolved them., For example, where one care plan did not have a mental capacity assessment this was completed and signed off promptly. We saw that there had been improvement over time. For example, in the January 2018 care plan audit, the service scored an average of 54% for compliance with its own standards of recording and information in care plans. In February this had improved to 85%. One member of staff said, "We get audits back. We get feedback on them; it comes up in supervisions as a plan of action to see where we can improve. Once a month the manager will come in and do a full sweep of audits."

Staff told us that morale had been up and down given the change in leadership of the service, however this was improving. Staff we spoke with were generally positive about the most recent changes in leadership, some expressed apprehension but were hopeful that positive changes would occur. One member of staff said of management changes that, "It's had an impact on staff morale. Probably with staff coming in fed up. Not knowing who we are working for or going to." However, they told us that, "I'd feel comfortable going to the new manager with any problems. Things seem to be slowly getting back to the way things were". One staff member said, "I think the manager is approachable, I can go to her with any concerns. She did introduce herself and set our vision." Another member of staff said, "When the previous manager left it was very hard. Morale dropped. But since the new manager has taken over things have really boosted. At first I

wasn't sure but I had a meeting and got very constructive feedback and a lot of praise which we never had before."

Staff had not had regular staff meetings prior to the change of manager. One member of staff said, "I don't remember having a meeting under the previous manager. The new manager had a meeting with care staff and a lot of them came out the meeting feeling really reassured thinking it will get better and I think it did reassure them." We reviewed meeting minutes and found the meetings were well attended and a range of topics relevant to the running of the service were discussed.

All staff we spoke with told us they felt enthusiastic about their roles and that they would recommend the service to people they knew.

There were meetings for residents and relatives to attend. One relative said, "I've never been to one because I always go to the manager if I need anything but I know they are there." Other relatives we spoke with were aware that they were on offer. The service had a 'you said, we did' board, which showed action that had been taken as a result of relative and resident feedback, one example was the new café for residents and relatives.