Bupa Care Homes (BNH) Limited

Amberley Court Care Home

Inspection report

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

Summary of findings

Overall summary

This inspection took place on 23 and 24 November 2016 and was unannounced. At our last inspection in November 2015 we found that the provider 'required improvement' in two questions, namely safe and well-led and was found to be 'good' the remaining three question effective, caring and responsive.

Amberley Court Nursing Home provides accommodation, nursing and personal care for up to 62 people with physical disabilities. The service had 15 Enhanced Assessment Beds (EAB). These beds are allocated to people who have been discharged from hospital but need extra support before they return home. There were 57 people living at the service at the time of our inspection.

There was a new manager in post who had not yet registered with the Commission. 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 were supported by staff who had been trained in how to recognise signs of abuse and were aware of what actions they should take should they suspect someone was at risk of harm. Staff were aware of the risks to people on a daily basis and how to manage those risks. Where accidents or incidents had taken place, action was taken and lessons were learnt.

People were supported by sufficient numbers of skilled staff who had been recruited safely. People did not always receive their medicines as prescribed.

Staff benefitted from an induction that prepared them for their role and received training that provided them with the skills they needed to meet the needs of the people they supported. Staff had not regularly received supervision and were not given the opportunity to formally discuss their learning and any concerns they may have.

People were supported by staff who obtained their consent prior to supporting them.

People were supported to have sufficient amounts to eat and drink. People's dietary needs and preferences were adhered to.

People's healthcare needs were met and they were supported to access a variety of healthcare professionals to ensure their health and wellbeing.

People were supported by staff who were kind and caring but people's dignity was not always respected. People were supported to make their own decisions and to maintain their independence.

Staff were aware of people's interests, how they wished to be supported and what was important to them. Plans were in place to provide more support to people to pursue activities that were of interest to them. People were aware of how to make complaints and where complaints had been raised, they were investigated and actions taken.

Changes in management had created a period of unsettlement at the service and not all staff were fully on board or aware of the manager's vision for the service. The manager was praised by staff for her commitment to the people living at the service.

There were a number of quality audits in place to identify any areas of improvement that were required within the service. Where areas where identified, action plans were put in place to address any issues.

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 consistently safe.

People did not always receive their medicines as prescribed.

People were supported by staff who understood their responsibilities to keep people safe and protect them from harm. Staff were aware of the risks to people on a daily basis and how to manage those risks.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by staff who had been trained to meet their needs and obtained their consent prior to supporting them. Staff had not received regular supervision which would provide them with the opportunity to discuss their learning. People were supported to access healthcare services and maintain good health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were supported by staff who they described as kind and caring but people's dignity was not always respected.

Is the service responsive?

Good

The service was responsive.

People were involved in the planning of their care and supported by staff who were aware of their likes, dislikes and preferences. Where complaints had been received, they had been investigated and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There had been a number of management changes at the service and not all staff were aware of, or on board with the manager's

vision for the service.

The manager was praised by staff for her commitment to people living at the service.

Quality audits in place had identified concerns that had been highlighted during the inspection and action plans were in place.

Amberley 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 23 and 24 November 2016 and was unannounced. The inspection was carried out by one inspector, a specialist advisor and an expert by experience. The specialist advisor was a nurse with experience of dementia care and medicine management. The expert-by-experience was a person who had personal experience of using or caring for someone who uses this type of care service.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we held about the provider, in particular, any notifications about accidents, incidents, safeguarding matters or deaths. We asked the local authority for their views about the service provided. We used the information that we had gathered to plan what areas we were going to focus on during our inspection. We spoke with ten people who lived at the service, one relative and four visiting healthcare professionals. We spoke with the manager, the area manager, regional manager, the deputy manager, two nurses, two unit managers, four care staff, the chef, housekeeping supervisor and the maintenance person.

We 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 reviewed a range of documents and records including the care records of five people using the service, 11 medication administration records, two staff files, staff induction records, accident and incident records, complaints and quality audits.

Requires Improvement

Is the service safe?

Our findings

We reviewed 11 Medication Administration Records (MAR) and found that two people's medical conditions were not always being treated appropriately by the use of the medicines, for example, one person told us on two occasions, they had not received their pain relief as prescribed. They confirmed that when they were originally admitted to the service they only had five days' supply of their pain relieving medication. The service was aware that it took up to seven days to register a person with the local surgery and for their records to be transferred to the surgery before they could prescribe any medication. Despite the service chasing the surgery for the additional medication, the person was without strong pain relief for a total of 48 hours and were offered paracetamol as a substitute. Following this incident an action plan was put in place to ensure for all new people admitted to the service, they came with two week's supply of medication. We observed another incident regarding the same individual who did not receive the same medication for 24 hours due to changes in dosage and communication issues with the GP.

For another person, who required their medication to be administered at a specific time, we saw a gap in their MAR chart which would indicate that they had not received their medication. We saw that a visiting healthcare professional had highlighted this as a concern and had instructed staff on the importance of these medicines being administered on time every day. However, the following month, we found three gaps in the person's MAR chart that would indicate that they had not received their medication. We were unable to evidence whether or not this medication had been administered. This meant that lessons had not been learnt following the previous error.

We found gaps and inconsistencies in recording in some MAR charts and instances of charts not being completed consistently [following the providers own system] which meant it was difficult to demonstrate what had been administered and what had not and why.

The areas of concern that had been highlighted during the inspection had also been identified by a recent medication audit and we saw that an action plan had been put in place to address these errors.

Some people said they received their medication on time and if they had pain they could ask for pain relief and this was offered. A relative told us, "[Person] always has his medication on time, I've no concerns".

We observed a nurse administering medication in a safe manner and checking if people required pain relief. We saw that medicines were stored securely and for people who required medicines that where to be administered 'when required' protocols were in place to advise staff of the circumstances in which the medication should be administered.

At our last inspection, people told us there was not always enough staff available to support them. At this inspection, we asked people if they thought there were enough staff to support them in a timely manner, comments received included; "Yes [there are enough staff on duty] but they have to work all hours to keep up", "Too many staff during the daytime!" and "Response to the call button is good, normally within five minutes". Staff spoken with told us they felt there were enough staff to meet the needs of the people they

supported and confirmed that staff absences were covered by the existing staff group. We observed that people were responded to in a timely manner. One person told us, "There's not enough staff at night; there's only two or three". We discussed this with the manager who confirmed that staffing levels were assessed against the dependency levels of the people living at the service and we saw evidence of this.

People were supported by staff who were aware of their responsibilities when it came to acting on and reporting any accidents or incidents. One member of staff told us, "If there was an accident, I would speak to whoever is in charge and will write in the accident record. Whenever there is an incident, it's a learning opportunity, if someone is prone to falling you make sure you put things in place to prevent it happening again". We saw where accidents and incidents had taken place, they were reported, investigated and analysed for any trends in order to learn from any mistakes that had taken place.

People told us they felt safe in the service, in terms of their health, their personal belongings and the risks to them on a daily basis. One person told us, "I do feel safe, I can shower myself" and another person told us, "I do feel safe. They [staff] know me and I know them". Staff told us they felt people living at the service were safe.

Staff spoken with were aware of their responsibilities with regard to keeping people safe. One member of staff told us, "If I saw something I would report it", adding, "[Deputy manager's name] will always put in place what needs to be put in place". Where safeguarding concerns had been raised, we saw evidence of investigations and where appropriate, lessons were learnt and action taken to prevent further incidents.

Staff were aware of the risks to people on a daily basis and were able to provide us with a number of examples of how they supported people to manage those risks. For example where a person was at a heightened risk of developing pressure sores, this had been recognised and changes had been made to their daily routine in order to reduce the risk. Efforts were also made to increase their nutritional intake. A member of staff said, "[Person] has to rely on someone to assist him at mealtimes. If he doesn't get his food at the right time he will refuse it". We saw that risks to people were reviewed on a regular basis, a member of staff told us, "We need to review all the time when we see changes or at least every month".

We saw that there were recruitment processes in place to help minimise the risks of employing unsuitable staff. We spoke with staff who confirmed that reference checks and checks with the Disclosure and Barring Service (which provides information about people's criminal records) had been undertaken before they had started work.

Requires Improvement

Is the service effective?

Our findings

People told us they considered the staff who supported them to be well trained and able to meet their needs. One person told us, "They're [staff] really good, they understand" and another said, "Yes, they're [staff] all very good".

People were supported by staff who benefitted from an induction that prepared them for their role. We saw that the service had implemented the Care Certificate, which is the national set of induction standards in the care sector. Staff induction provided new staff with the opportunity to shadow other more experienced members of staff prior to working alone on shift. A member of staff told us, "I did my induction and all my training that covered everything and then five days of shadowing. Any support I needed I got from the seniors".

Staff told us they received training that provided them with the skills they required to meet the needs of the people they supported and considered themselves to be well trained. One member of staff told us, "If I want to do something different, I can just ask". The trainer who was responsible for training staff within the service told us that it was the responsibility of the manager and senior staff, through individual supervision, to highlight any gaps in staff knowledge. However, staff told us they had not received formal supervision for some time. One member of staff told us, "I haven't had supervision for about two years. I just plod along and if I'm not happy about something or unsure I would just go to the manager" and another said, "I haven't had supervision for at least six months". Another member of staff told us they would welcome the opportunity to discuss their learning or concerns that they may have and provided us with personal reasons for this. We discussed this with the deputy, she told us, "Supervision is a problem, we're aware of it and the manager has said she will supervise me and then I will cascade responsibility through the team, it should be done in the next three months". We also had it confirmed that there were no spot checks taking place to observe staff practice, although one member of staff commented, "If the deputy wasn't happy and wants you to do something differently she will just say". The lack of consistent supervision meant that staff were not given the opportunity to formally discuss their learning and any concerns they may have.

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).

People told us that prior to supporting them, staff obtained their consent and we observed this. 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 saw that where there were DoLS in place, best interests meetings had taken place and the correct paperwork had been completed. Staff knew that they should gain people's consent before providing care and support and ensure that care was

delivered with people's best interests in mind. However, some staff were unsure as to who had a DoLS authorisation in place and what this would mean when it came to supporting those individuals lawfully. For example, one member of staff told us, "We had a gentleman with one [DoLS] in place and it was explained to us but I still don't understand". Another member of staff told us they were not aware of who had a DoLS in place but were able to explain what it meant for people and the need to make decisions for people that were in their best interests. This lack of understanding meant that the manager could not be confident that all staff were supporting people in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff told us that communication throughout the service was not as effective as they thought it could be. They told us they were no longer provided with a copy of the handover sheet for them to refer to whilst on shift, that handover was verbal and they had to access the written information kept on the nurse's station. A member of care staff told us, "It [written handover] was very helpful and let you know where you stood. Information is not always passed on". We discussed this with the manager who advised that changes had been made due to concerns regarding confidentiality. A relative provided us with an example of poor communication between themselves and care staff. They described an occasion where they were told last minute that their loved one had a hospital appointment. They told us, "I would have liked to have been there, if they had given me the appointment earlier, I could have been there".

We spoke with a group of visiting healthcare professionals who visited the service on a regular basis to ensure the people who were in the enhanced assessment beds were receiving the appropriate care and treatment prior to them returning home. They told us that previously communication between themselves and the management at the service had been poor, but since arrangements had been made to delegate the responsibility of communicating with health care professionals to a senior care member of staff, communication had improved and people's needs were being met.

People told us they were offered a choice at mealtimes and could ask if they wanted something different on the menu. Comments received included; "Well yes [meals are good], but I would say we don't get enough", "Really nice; [chef's name] on duty today, so that's even better!" and "Lovely meals, but I'm putting on the weight. I need one of them bikes" [gym bikes]. We observed people had access to fruit, snacks and hot and cold drinks at all times. The chef had been with the service for a short amount of time. He was aware of people's dietary needs and was able to provide us with information regarding people's particular preferences, for example how people like particular meals cooked. He told us he was kept up to date with the dietary needs of people at the service by the nurse or care staff. The provider told us in their Provider Information Return that plans were in place to improve the provision of food and people's mealtime experience and we saw that action plans were in place to address this.

People told us that if they felt unwell, they were able to ask to see their doctor. Comments received included; "The nurses here are OK, it takes a while to see a doctor, they're very slow" and "Yes the doctor comes round every Wednesday". We saw evidence to demonstrate that people were supported to maintain good health. Where one person was identified as being a risk of losing weight, they were referred to the dietician and changes were made to the person's diet. We saw that the manager went to great lengths to identify and source services that would support people at the service. We found that one person needed their nutrition via a tube fitted directly into the stomach because their oral intake was not adequate. We saw that the instructions for this were well documented but the regime was not being adhered to correctly. Care plan audits had failed to identify this error. We shared this with nursing staff on the day. We saw where changes in people's medical needs were noted, care plans were updated and additional guidance provided for staff to follow. For example, staff noted blisters on a person's foot. We saw that immediate action was taken to minimise the risk of further damage to the person's skin and staff obtained further medical advice

and equipment in order to minimise the risk.

Requires Improvement

Is the service caring?

Our findings

People told us that staff who supported them were kind and compassionate. One person told us, "They're [staff] very friendly. They made sure I've got my own stick [pool cue] and my own chalk", other comments included, "Oh, they're nice people alright" and "The staff are caring, it's all very relaxed and we share a joke". We observed interactions between people and staff to be friendly. There was a lot of laughter at the service and we observed that people were fond of the staff who supported them.

Staff we spoke with were able to tell us how they supported people in order to maintain their privacy and dignity. One member of staff told us, "I always make sure curtains are closed, and keep the person covered up as much as possible. If someone knocks on the door I'll say, can you give me a minute". One person told us, "Yes staff do respect my privacy", but another person commented, "Privacy and dignity are not preserved; they [staff] find it hard to differentiate between caring and being polite".

We observed that people received different experiences at mealtimes, in one dining room, the atmosphere was pleasant, busy and people interacted well, this was supported by the member of staff who was responsible for the dining room experience. In another dining room, staff were busy coming in and out of the room to collect people's meals. Some people were given a tabard to wear to protect their clothes, but some staff did not ask the person if they wanted to wear it and just placed it on them. We observed some lovely interactions between some staff who made the effort to acknowledge people and chat with them, but noticed that not everyone benefitted from this experience. A relative commented, "There are some carers who genuinely care and those who pretend to care. Some are caring and others are going through the motions". We discussed the dining room experience with the manager. We saw that audits had identified these issues and arrangements were in place to improve the dining room experience. Hostesses [meal time staff] were involved to assist at mealtimes and we saw where this had been introduced in one area of the service, it had made a positive impact.

People told us they were involved in making decisions about how they were supported, one person told us, "Yes, they [staff] listen to me" and another said, "I just have to knock on [manager's door" [to speak to her about anything]. People told us they felt listened to and were supported to be as independent as possible. One member of staff told us, "I try and get people to do as much for themselves as possible. Prompt and try and encourage them". We saw that visitors to the service were encouraged and people told us that their family and friends could visit at any time.

We were told that no one at the service currently had an advocate. Staff spoken with were aware of advocacy services and were able to tell us how these services had benefitted people in the past.

Good

Is the service responsive?

Our findings

People told us they had been involved in discussions regarding their care and had contributed to their care plan and we saw evidence of this. Staff demonstrated a good knowledge of the people they supported and what was important to them, their likes, dislikes and preferences. They were able to provide us with detailed examples of how they supported individuals and responded to their needs. A member of staff described how they supported a person on a daily basis and knew how to respond to their particular needs. They told us, "When [person] is low, I encourage her to talk" and another member of staff described their relationship with a person they supported, what was important to them and how they preferred to be addressed.

A relative told us, "Some [staff] know about [person], what he used to do before he came here". A member of staff told us, "When new people come in, you're given the basic information about them and their needs and everything else you have to build up your own knowledge". We saw that care plan reviews took place regularly, a member of staff told us "Reviews take place monthly but if something changes we will change it there and then". A relative spoken with told us they had not been invited to a review and felt it was something they would benefit from and they intended to raise this with the manager.

We saw that staff allocations were done on a weekly basis in order to respond to the changing needs of the people living at the service. A senior member of staff described to us the changes put in place on a daily basis in order to support people. She told us, "I know that [staff name] is the best person to support [person's name] when they want a shower, you try and get the staff mix as best you can to respond to people's needs".

People told us they were supported to access the community and participate in activities that were of interest to them, but the manager told us this was an area she had identified that required more input and two additional activity co-ordinators had been appointed to address this need. One person told us, "I go out on my own, go the pictures, I like to do quizzes, like to read newspapers and go to church at the weekend". A relative told us, "[Person] has been taken out at times and he does some things in the activity room. The manager arranged for animals [from pet visiting service] to come in which [person] liked". A member of staff told us, "We have been making Christmas cards, we do lots of activities and we're doing some Christmas shopping". We saw that there was a computer suite in use for people to use. The manager had requested updated equipment to replace what was being used. We saw there were plans to make another room available as a gym in order to support people who wished to become more physically active and plans for a multi-faith prayer room, to support people with their cultural and spiritual needs.

People told us they felt comfortable raising any concerns or complaints they may have. One person told us, "I've raised a complaint before and they [staff] did listen to me". We saw where complaints had been raised, they were investigated, responded to and where appropriate, lessons were learnt. A relative told us of a concern they had raised and how it had been dealt with. They told us, "When the new manager turned up I raised it with her and it's been sorted now and they are sticking to the regular routine". We saw that people had access to the area manager, either by phone or in person, should they wish to discuss any concerns they may have.

We saw that the manager had made efforts to obtain feedback from people regarding the service they received. People told us that meetings for them had taken place, although the minutes were not available for the last meeting that had been held in November 2016. The manager told us that she planned for the meetings to take place monthly. She told us, "As soon as I know the induction dates of the activities staff I will plan the next meeting".

Requires Improvement

Is the service well-led?

Our findings

Since the last inspection, the previous manager had left and the regional manager had stepped in whilst a replacement was found. The new manager had been in post for approximately eight weeks, which included her period of induction. It was recognised that the recent changes in management had led to additional challenges for people living at the service and staff alike. The lack of consistent management had meant that staff had not benefitted from regular supervision and this in turn had had an impact on care delivery for some people living at the service. One person told us, "The manager is so busy fighting this fire [referring to any single issue] that she can't see the whole care home's going up in flames!" another person said, "It's a new lady; she seems alright".

The new manager used a wheelchair and her arrival was seen as a positive appointment for the service. One person told us, "I know the manager very well, she is very positive and has more insight into being in a wheelchair" and the regional manager said, "The manager is coming in from an unique perspective, seeing things from the position of her being disabled". The manager told us that being a wheelchair user provided her with valuable insight into the challenges that faced some of the people who used the service.

We received a mixed response from staff with regard to the new manager in post. No staff doubted her commitment to the people living at the service or the challenges that faced her in her new role. One member of staff commented, "She [manager] has a lot of knowledge. This is not an easy home to manage" and another member of staff said, "[Manager's name] has a lot of good ideas but it's the way you do it and the approach". Other staff spoke positively regarding the manager and support she had offered. One member of staff said, "She [manager] has supported me. I can't knock her for that, but I can't say the same for everyone. She is very passionate, but I'm not aware of what direction she wants to take things". The regional manager commented "She [manager] is changing years of culture and doing it very well".

The manager told us, "They [staff] are a good bunch, some really amazing people here" she told us how keen she was to make sure staff felt valued and had introduced an 'Employee of the Month' award. People were encouraged to nominate staff who had provided them with support that made them feel safe, cared for and treated like an individual. One person told us, "There is a form, a paper you can fill in. They're very friendly about it". We saw that a number of people had used this system to nominate staff and the first employee of the month had been nominated for his 'kindness, willingness to help and to focus on people and their needs'. Staff acknowledged the positive impact some of the improvements the manager had bought in, including the 'Employee of the Month' with one member of staff stating, "It's a good boost to staff morale".

It was evident that the new manager was passionate about her role, educating and empowering people to live the way they wanted. We observed that the manager knew people well, she was able to provide detailed information regarding people's healthcare needs and what was important to them. One person told us, "The manager, yes, I see her all the time" and another person said, "Friendly staff, and the managers have always been very approachable". However, another person told us, "I waited four hours to see the manager, I think she doesn't have time for residents" and a member of staff corroborated the long wait.

We observed the manager speak to staff positively and enthusiastically, introducing staff to the inspection team and announcing their best qualities in the introduction, such as, "I employ these people because they have a heart". The manager told us she felt well supported by the regional and area managers. The regional manager said, "The manager is very open to staff giving views and opinions and staff can talk to me if they want to raise a concern. The regional director is very contactable as well".

The manager had described to us the challenges she faced and how she was trying to get staff to open up to her. We saw that she had introduced a system whereby staff could raise concerns with her in writing that no one else had access to. However, some staff provided us with examples where they had raised concerns with the manager and they had not been dealt with sensitively. From the conversations we had with staff, not all of them were fully aware of the manager's vision for the service and did not feel involved in this. They told us the manager had introduced a number of changes, many positive, but other changes had been bought in with little or no consultation or explanation as to why they were happening. There had been a staff meeting when the manager first arrived, but nothing since. Staff told us if they had concerns they would raise it with their line manager, but would welcome the opportunity to have a formal meeting in order to be listened to and voice their concerns. This lack of communication, coupled with the lack of supervision giving staff the opportunity to discuss or raise any concerns they may have, meant that the manager did not have the staff group fully on board with her vision for the service.

The provider told us in their Provider Information Return that new quality assurances processes were being embedded into everyday practice in order to help drive improvement at the service and we saw evidence of this. These included [amongst others] medication audits, care plan and skin care audits and feedback from people living at the service. Where audits had taken place which identified areas that required action, these were included in the home improvement plan. The Area Manager also conducted regular audits and both she and the regional manager were familiar faces around the service. Many of the people living at the service referred to them both by their first names and confirmed they were accessible to them, should they wish to discuss any concerns or worries they may have. We saw that the concerns that had been highlighted during the inspection had been identified at a number of recent quality audits and action plans were already in place in order to address the concerns raised.

The provider had notified us about events that they were required to by law and had on display the previous Care Quality Commission rating of the service.