Care Quality Commission

Bupa Care Homes (CFHCare) Limited

Anglesea Heights Nursing 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?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This was an unannounced inspection carried out on 29 and 30 October and 6 November 2014. At the last inspection on 16 February 2014 we found a breach of legal requirements as staffing levels were insufficient and people's dignity was not always respected. An action plan was received from the provider which stated they would meet the legal requirements by April 2014. At this inspection we found that action had been taken with regard to these breaches but further improvement was still required.

Anglesea Heights provides accommodation, personal care and nursing for up to 120 people. The service mainly provides care to people who are living with dementia, and/or require nursing and palliative care. There was a total of 115 people living in the service at the time of our inspection. There are four bungalows; Alexander House, Gyppswick House, Christchurch House and Bourne House, each provides single bedrooms with ensuite facilities for up to 30 people. Staff refer to these as "bungalows" or "units".

Summary of findings

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had a range of systems in place to inform them of what was going on in the service however actions to address issues that were identified were not aways taken promptly. There was a lack of managerial oversight of the service as a whole and there was inconsistency in quality across the service. The registered manager was unable to demonstrate how they identified where improvements to the quality of the service was needed.

Staff told us that the culture of the service was not always open and transparent and communication was poor. Key challenges facing the service to those that used it or were involved in it were not discussed with staff. Staff meetings and one to one meetings were not held regularly to inform and support staff in their day to day practice.

Staff training was not monitored and planned effectively and staffs competency and understanding was not assessed regularly . Specific training relevant to people's needs was not provided to enable staff to have the right knowledge and skills to meet their needs.

The service was experiencing problems in retaining staff and covering staff absence. In response to this temporary agency staff were being employed and new staff were being recruited. Call bells were being responded to promptly however care was mainly centred on providing for people's immediate and personal care needs. Some people lacked effective social interaction that promoted their wellbeing and gave them a pupose.

Relatives told us that their family members were treated with kindness and respect by staff. Staff understood and described how they could recognise various types of abuse and who to report any concerns to. There were appropriate arrangements in place to ensure people's medicines were obtained, stored and administered safely.

Where people lacked capacity it was not evident that decisions had been made in their best interests. Staff had good relationships with people and interacted with people in a caring and respectful manner. At mealtimes people's dignity was not always maintained and choice was not always promoted. People did not always receive the encouragement they needed to eat and drink well.

There was a system in place to respond to complaints. However relatives told us that concerns raised verbally were not considered seriously and in some cases resolved satisfactory.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of this report.

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?

Requires Improvement

The service was not consistently safe.

There were not always enough staff to meet people's social and emotional care needs. The service was currently recruiting new staff.

People and their relatives felt the service was a safe place to live. The provider had systems in place to manage safeguarding concerns and people's medicines.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive effective training to ensure they had the right knowledge and skills to carry out their roles. Staff were not adequately supported in their day to day practice.

People were not always supported and encouraged to eat and drink enough.

Where people lacked capacity it was not evident that decisions had been made in their best interests.

People were supported to access appropriate services for their on going healthcare needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We observed some warm and caring interactions between staff and people but people's dignity was not consistently maintained across the service and their choice not always promoted.

Good initiatives were implemented and followed by staff to ensure people at the end of their lives received their care in a joined-up way from health care professionals involved and how they wished it to be.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's social care and emotional needs were not being properly assessed, planned and delivered.

Not all people's care plans were sufficiently detailed to enable staff to deliver consistent, personalised care that met people's individual needs.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Summary of findings

The overall culture of the service was not inclusive, supportive and informative.

Principles of good quality assurance was not always followed to ensure a proactive approach was taken in the development and improvement of the service. Systems did not ensure quality was consistent across the service.

Anglesea Heights Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 and 30 October and 6 November 2014. This was an unannounced inspection and the team consisted of two inspectors and an Expert-by-Experience. This is a person who has personal experience of caring for older people and people living with dementia.

As many of the people who live in the service had dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not express their views and experiences with us.

We spoke with four people and four visitors. We also spoke with five nurses, two senior care staff, nine care staff, two activity co-ordinators, the deputy manager, the clinical manager, two unit managers and the registered manager. We looked at six people's care records, 12 people's medication records, six staff records, staffing rota's and records relating to how the safety and quality of the service was monitored.

Before our inspection we reviewed the information we held about the service including notifications of incidents that the provider had sent to us since our last inspection. We also looked at information we had received from other professionals including commissioners of care from the local authority and clinical commissioning groups.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in February 2013 we were concerned that there were not enough staff on duty to meet people's needs. The provider sent us an action plan outlining the improvements they were putting in place which they said would be in place by the end of March 2014. At this inspection there was further to go to ensure improvements made were consistent and sustained across all areas of the service.

The provider had increased staffing numbers by one member of staff on each shift, on each bungalow. However two bungalows (Gypswick and Alexander) were experiencing on going problems in retaining staff and covering staff absence. There were still times when there were insufficient staffing numbers to meet the needs of people. Staff told us there were not enough staff in post to cover the increase and they or their colleagues would often be deployed to cover where there were staff shortages. They felt that this then impacted on the area they had been moved from. One visitor told us that there was a stable core of experienced and dedicated staff that set good standards however staff were busy and their relative was only offered a bath or shower once a week. They told us that this was not enough to meet their needs. Social care professionals told us that morning times were often rushed leaving people waiting to get up or getting up before they would like to.

We saw staff did not always have enough time to spend with people to meet their needs at a pace that suited the person. For example we saw in one case that staff did not take the time to communicate effectively and orientate a person new to the service to the time of day and their surroundings. This did not help the person to understand, develop trust and reduce their anxiety.

Many people required two staff to assist with all of their personal care. The way the service calculated the amount of staff needed did not take account of individual needs and time taken to provide the assessed care and treatment. The registered manager told us that they were currently recruiting new staff and they were looking to employ staff on flexible hours to cover busier times to meet people's needs more effectively. They told us they felt this would ensure the extra staffing would give a more consistent service in all areas..

The provider had a safe and robust system in place for the recruitment and selection of new staff. Required checks were undertaken and references sought to ensure that staff were suitable to work with vulnerable people. This ensured that staff were appropriate to carry out their role.

People told us staff treated them very well and they felt safe at the home. Staff told us that they had completed training to help them recognise and report concerns. They were confident to report any issues to the nursing sister or unit manager in the area they were working. One staff member said, "I would be concerned if someone becomes anxious, quiet or unresponsive and I would raise this immediately with the nursing sisters. They are approachable and would listen to my concern." The provider's safeguarding adults and whistleblowing policies and procedures were available to informed staff of their responsibilities to ensure that people were protected from harm. They reported concerns to the local authority appropriately and completed investigations when it was appropriate to do so.

Medicines were stored securely. The temperature of the clinical room in one of the bungalows was too warm for the safe storage of prescribed medication. The effectiveness of some medication can change in a warm temperature. Medication was provided to people efficiently and in a timely manner. We saw that medicine administration was divided up on each bungalow between two nurses, each with their own medicine trolley to reduce the length of time taken and ensure people received their medicines on time. Checks were undertaken after each medication round to ensure that people had received their medication as prescribed and the records were completed. The deputy managers provided cover to administer medicines to people when there was not enough trained staff on duty to do so. Medicines were administered by staff with patience and understanding and they spoke with people about their medication explaining what it was and what it was for. Medication administration charts showed that people received their medication as prescribed, were offered pain control when they needed and had their topical creams applied when they received their personal care.

Risk assessments for moving and handling people or having bed rails in place did not reflect best practice guidance. Where people living with dementia had bed rails their capacity, understanding and other least restrictive options had not been considered within the risk

Requires Improvement

Is the service safe?

assessment and therefore could potentially place them at risk of injury. Moving and handling assessments did not specify the individual equipment the person needed such as type and size of hoisting sling that was required in relation to daily activities and the hoist to be used. People can experience discomfort or a fall if the wrong sized sling is used. The registered manager said they would look at this immediately to ensure people were safe.

Where risks were identified to people's health and wellbeing such as the risk of skin damage, eating and drinking and falls risk assessments and management plans were in place to guide staff on the measures in place to reduce and monitor those risks, during delivery of people's care. Risk assessments were reviewed each month, or as circumstances changed, and appropriate actions taken where necessary. For example where someone had recurring falls a referral to a GP was made for a review of the persons medication which was believed to be the cause. Other action had been taken in the mean time to keep them safe.

Inadequate

Is the service effective?

Our findings

Staff training and development was not sufficient in some areas to show that people's healthcare conditions were fully understood by staff so their needs were recognised and met consistently. People were at various stages of their dementia condition ranging from early onset to advanced stages. Staff told us that they had received a basic level of training in dementia; they said that they would like, and needed, further training to enable them to support people more effectively by understanding how the condition progressed. Some staff did not demonstrate an understanding of dementia and how this affected people in their day to day living. They were unable to tell us how they could support people to reduce their anxieties. Some staff lacked knowledge about people's backgrounds and past lives which would have enabled them to explore different ways of communicating and understand more about the person they were supporting. The manager told us that this had been acknowledged and would be addressed as part of new training in dementia care.

Managers in Alexander House had training and were able to lead staff in end of life care best practice. However this was inconsistent across the whole service despite all areas providing care to those nearing the end of their life. Staff told us this was an area of training they felt they needed. The service cared for people with Parkinson's disease, multiple sclerosis and diabetes but staff had not received training specific to enable them to recognise and meet those peoples needs more effectively. Staff told us that nurses had not received training to update their knowledge on current and best practice for leg ulcer treatment and care which meant they felt they were not able to ensure that the care they provided was the best available for people and reflected up to date care.

Staff told us that there were opportunities for study days but not specialised courses; they told us that they looked to the nurses to help them understand and learn. Study days were advertised for staff in subjects such as catheter care and stroke awareness but places were limited and staff told us that not all were enabled to attend due to their rota. There was no system in place to ensure that all staff had the knowledge and understanding of people's conditions to ensure care was consistently provided.

We were told by staff that the medication training consisted of eLearning with a test at the end and that there was no practical supervision or competency assessment undertaken with staff to ensure they were competent and safe to manage and administer people's medicines.

Support for staff learning and development was inconsistent. Staff told us that they did not have a personalised development plan which reflected professional development or specialisms linked to the needs of people they cared for. The deputy managers did not demonstrate an understanding of the purpose of supervisions and had not received any training in this area. One nurse told us that there was no structured supervision and that, "staff need supervision as many are unhappy and morale is low." The registered manager told us that supervisions happened as and when they felt they were required but they had recognised the shortfalls and a more effective supervision process was being planned. The registered manager could not give us information about who needed training and by when.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS), and to report on what we find. Our observations showed that staff practice demonstrated that the training was either ineffective or that staff required further training to ensure they applied and understood the principles of DoLS. These safeguards are in place to ensure that people's freedoms are respected and unnecessary restrictions are not put in place. We saw that staff did not understand the impact of using a gate to restrict some people's movements in some areas of the home. They had not taken the appropriate action to have this formally assessed to ensure it was in the best interest of the people affected. Staff had not recognised the potential impacts on people or explored alternatives to see if there was a more suitable and less restrictive approach.

This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were provided with opportunities to have enough hot and cold drinks throughout their day. Relatives said the quality of the food was variable. The menu choice was limited and vegetarian options were not always catered for. Staff said that they had to remind the kitchen daily about a person who is a vegetarian to ensure they were provided with a suitable meal. Staff said that, "Sometimes the quality of the cooking is poor" and "Sometimes the food is

Inadequate

Is the service effective?

too hard for some people to eat." They also told us, "Brown bread, which is more nutritious, was not offered as an alternative for people", "Sometimes the menu is changed without notice" and "Sometimes there is not enough food provided to go round."

The level of support given to people to eat and drink varied across the service. On Gypswick House where people had advanced dementia the support provided to them was not sufficient to ensure they ate enough. A relative told us that their family member was not sufficiently supported at mealtimes. They had been so concerned that they came in to assist their relative. They said that since then their relative's weight had increased.

People left to eat independently, particularly on Gypswick, had little interaction with staff which did not encourage or promote practical help to eat more either independently or with support. As a result some people ate very little of what they were served and staff did not explore this further.

People had access to other health professionals as required. Relatives told us that staff contacted them if they were concerned about their family member and if there had been any changes in their health care needs. Care records confirmed that people were seen by the GP when it was required and that other specialists such as chiropodists, speech and language therapists and palliative care team had been accessed.

We recommend that the service seek advice and guidance from a reputable source about how to support people in meeting their individual nutritional needs, particularly those with specialist needs including dementia.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in February 2013 we were concerned that people did not always have their dignity respected and promoted particularly at meal times. The provider sent us an action plan outlining the improvements they were putting in place which they said would be completed by the end of March 2014.

At this inspection we saw that improvements had been made but was not consistent. In most cases where people required one to one support at meal times staff sat beside them; they were patient and encouraging and the pace was set by the person eating and not rushed. However further improvement was needed as good practice in respecting and promoting people's dignity was not consistent. For example thought had not been given as to how people's dignity could be maintained when they were unable to be independent. Plastic beakers and tabards were given to people without asking them if they were wanted or consideration as to whether they may need them or not. During mealtime we saw one staff member overloading a desert spoon with food when assisting a person to eat and a social care professional told us that they had observed a persons mouth being cleaned by a staff member with the side of a spoon. Actions such as these did not show respect for people or demonstrate good practice.

Throughout our inspection we saw that the staff protected people's privacy. We regularly observed staff discreetly and sensitively reminding people about using the toilet. They knocked on doors before entering and ensured doors to bedrooms, bathrooms and toilets were closed when people were receiving personal care.

People's involvement in their own care including planning and making decisions was inconsistent across the service. People who were able were actively involved in making decisions about their care and supported to express their views. However people who experienced difficulty in making decisions and expressing their choice or preference were not always supported properly by some staff and information was not given to them in a way that they understood. For example on Gypswick where people were living with advanced dementia everybody was offered a choice of meal verbally by staff. In one instance a person was shown the two meals on offer which enabled them to make an informed choice. However another person was not shown the options to help them make their own choice and they received the meal that the staff member chose for them.

The majority of relatives that we spoke with told us that the staff were kind and caring to their family member. One relative said that they would recommend the service because of the quality of care their family member received and "I admire the staff for their dedication." Another told us staff were "Caring and compassionate" and when a person was anxious they were treated with "Great empathy." Another relative said that the staff showed concern for their family member's happiness and that, "My original fears about entrusting my [family member's] care to a care home has been completely dispelled." We saw staff had developed positive and caring relationships with people. We observed a member of staff sitting with a person and looking at their photographs with them. The staff member was heard asking the person where they had been taken. The person was actively engaged with the staff member who showed patience and good listening skills.

People were supported to maintain contact with family and friends and relatives told us that they were always welcomed and that there were no restrictions on visiting times. One relative told us that their family member followed a religious faith and that a member of staff had asked them if it was acceptable for them to pray with their family member; they said that this now happens and provides comfort to their family member.

Alexandra House provided palliative care to people with long term or terminal conditions. Staff described how they ensured people at the end of their life were supported to have a comfortable, dignified and pain free death. Staff told us that Alexandra House was accredited with the Gold Standards Framework (GSF). GSF is a joint approach used by all professionals involved in a persons care that ensured they received appropriate and co-ordinated end of life care. We saw that this benefited people as staff worked closely with the local hospice, GP and other healthcare professionals and multidisciplinary care meetings were held when required to determine the best way forward to meet people's needs such as pain relief. Care plans set out people's preferences for when they reached the end of their life and the end of life care they wanted to receive so that

Requires Improvement

Is the service caring?

staff could support them to remain in the home and be comfortable at the end of their life. Staff ensured that all healthcare professionals were aware of people's preferences.

A remembrance and memorial day was held annually during December for families, friends and staff to remember and celebrate the lives of people who had passed away at Anglesea Heights.

Requires Improvement

Is the service responsive?

Our findings

People using the service and relatives told us that the activity staff "Do a very good job, they arrange social events and entertainment which are enjoyable to people who can attend." Throughout our inspection we saw activity staff interacting appropriately and at the right level with people in small groups and individually in the communal areas. One was showing pictures of old items to a group of four people and generating discussion of previous experiences and memories. Another was doing a craft activity with a person using tissue paper. This person although not participating in the activity was clearly enjoying the company and conversation. At other times we saw a person being accompanied by activity staff on a walk outside and activity staff facilitating a game of bingo.

Despite this positive interaction this experience was not consistent for people across the service. People who were able to spend time in communal areas had more social interaction with staff than those who spent the majority of their time being cared for in their bedrooms. Social care professionals told us that people who spent their time in their bedrooms had little stimulation, only that from staff performing a care task or when their relatives were visiting; they felt more could be done to engage with people.

Activity staff explained their role was to visit each bungalow for one hour per day (not including weekends). They also provided people with personal care at some times during the day. They explained this left very little time for them to engage regularly and meaningfully on an individual basis with people living with dementia and people receiving palliative care. Despite items being available for people which would generally aid stimulation or provide comfort and reminiscence such as rummage and memory boxes; they were not freely accessible or encouraged by care staff. This left people without many opportunities to independently entertain themselves.

Relatives who were visiting the service told us that they had been asked about their family members life history, likes and dislikes when they first moved into the service which enabled some staff to have some knowledge about the person and not just their care needs. However, we found inconsistencies across the service in the quality of the information included in people's care plans which were followed by all staff. Some provided sufficient detail to give staff the information they needed to provide personalised care and support that was consistent and responsive to their individual needs. Others did not contain enough relevant detail on how people's dementia affected their day to day living and how they were to be supported. They did not include detail about people's strengths and aspirations, past lives, hobbies, pastimes or social histories which would help all staff to understand the person. Relatives told us they were not involved in care planning and in most cases had not seen their relatives records.

Care staff told us nurses wrote care plans but they would like to be involved because they were people's main carers and knew more about them. Some staff said care plans were difficult to understand or they were difficult to read. They said they learnt about people through their lifestyle document entitled 'Who Am I'. However we found that these documents had not always been updated to reflect where people's abilities had changed and the additional support they required. This meant they were at risk of providing care which could be unsafe or inappropriate.

Daily records did not give any indication of how the person's day was spent nor did they give any reference to their wellbeing. Where there were notes that showed the person had not had a good day there was no information as to why or how staff supported them at this time. This lack of records did not show if staff were providing personalised care which promoted people's independence and met their needs.

A relative told us that they did not feel concerns they had raised with staff had been taken seriously, addressed and resolved satisfactory. Staff told us that any concerns raised went through an informal resolution process. They told us that a decision was made by the bungalow manager as to whether to report further to senior management. There were no arrangements in place to make sure any improvements needed were learned from formally so others benefited from the outcome. Staff were unaware of the outcome of concerns raised verbally and the registered manager told us they could not tell us this as records were only held in individuals care files. This meant the registered manager was unable to demonstrate how people's comments and views had been listened to and considered to ensure that improvements were made.

Requires Improvement

Is the service well-led?

Our findings

The provider had made some improvements to the quality of the service however further work was needed to ensure this was consistent and sustained. People, relatives and staff had varying views about the leadership of the service. Relatives told us that they knew and communicated with senior staff in charge of the bungalow's but had had very little to do with the registered manager. They felt this was mainly to do with the size of the service and the number of people using it. However, most staff felt well supported by their team, senior staff and manager of their bungalow. Comments from staff included, "The sisters in charge are very approachable and supportive, they always listen to my concerns" and "The unit manager is very supportive and our views are always respected" and "We have good values on [name of bungalow], high standards are set, we ask questions and the senior staff look for solutions, we are a very tight team."

Despite this staff felt that the overall culture across the service was not open and inclusive. Many felt that communication was poor and that they did not feel valued and respected by the registered manager or the provider. Reasons for this included that they felt they were not involved or informed about future plans or improvements for the service. They felt their views did not matter and they were not empowered to express their views. The registered manager told us that staff meetings were held at the discretion of the bungalow managers. Bourne House had not had a manager since March 2014. Despite this there had been no meetings to communicate with staff and offer support from the senior leadership of the service. Staff across the service told us that they rarely had contact with the registered manager or saw representatives of the provider. Others said that since the two deputy managers had been in post this helped to bridge the gap because they were visible on the bungalows on a daily basis and they knew the people and staff.

There was not a consistent approach to quality assurance to ensure effective development and improvement of the service. The bungalows were each managed in isolation by their own managers. There was a lack of managerial oversight of the service as a whole and the registered manager was unable to demonstrate how they identified where improvements were needed or applied learning across the service. Whilst analysis of incidents and risks did take place the action plan developed was not specific enough to ensure that they had a direct effect. For example an incident had occurred in October 2014 in relation to a medicine error. The registered manager was unable to explain how they were assured that lessons had been learned from this incident, that staff practice and competency was being improved as a result and the risk of reoccurrence across the service had been reduced.

In another example staff told us that an air conditioning unit had not been working for more than two years in an area storing medicines. The effectiveness of some medication can change in a warm temperature. We noted this was identified as a risk by the provider in July 2014. An action plan stated that this was to be referred to the maintenance man and estates manager. Action to address the issue and the potential risks had not been minimised as the registered manager could not tell us what, if any action had been taken.

The registered manager was unable to demonstrate how the views and experiences of people were explored. Satisfaction surveys were carried out each year by the provider to gather peoples views and experiences across all of their registered services. However this process was not only focussed on this service and therefore only 20 surveys were dispatched and 13 returned. This is a small number to rely on to reflect the views of people in a service that accommodates up to 120 people. Whilst the results of this survey were good overall there was no information how the service was going to drive improvement for people .

Relatives meetings were held on each bungalow approximately twice a year. Attendance was low and on the day of our inspection there were no attendees to a meeting scheduled for Gypswick. Staff told us that this was not unusual across the bungalows. Minutes of meetings showed that the meetings were not proactive and definitive actions were not carried forward or feedback in response to issues that were raised.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place in order to ensure that staff were appropriately supported in relation to their responsibilities, to enable them to deliver care and support to people safely and to an appropriate standard.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered person did not have an effective system to regularly assess and monitor the quality and safety of care that people received and ensure consistency across the service.**