Mrs Eleni Panayi

Bolters Corner Nursing Home

Inspection report

Bolters Corner
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Ratings

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

Overall summary

Bolters Corner Nursing Home provides accommodation and nursing care for up to 35 older people living with dementia and several other physical disabilities. The home is locates on the outskirts of Banstead Village within access to local amenities. A lift provides access to the first floor. The home is owned by Mrs Eleni Panayi and managed by her son who is the registered manager.

The home had a registered manager in post on the day of our 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 and associated Regulations about how the service is run.

We looked at the medicine policy and found all staff gave medicine to people in accordance with this policy.

Summary of findings

However we found issues regarding creams and lotions not being dated when opened and found medicines stored in the fridge were either out of date or no longer in use.

People told us they were treated well by staff who were kind and caring. People's privacy and dignity was respected. We saw staff knocked on people's doors before they entered, and personal care was undertaken in private.

People told us they felt safe. Staff had undertaken training regarding safeguarding adults and were aware of what procedures to follow if they suspected abuse was taking place. There was a copy of Surrey County Council's multi-agency safeguarding procedures available in the home for information and staff told us this was located in the office for reference.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLs) which applies to care homes. The manager and staff explained their understanding of their responsibilities of the Mental Capacity Act (MCA) 2005 and DoLS and what they needed to do should someone lack capacity or needed to be kept safe. We saw people who required a DoLS authorisation had these in place.

Staff had a good understanding of the Mental Capacity Act 2005 and had undertaken training in this. We observed mental capacity assessments had been completed and best interest meetings undertaken where appropriate.

Risk assessments were in place where people had an identified risk. For example a person was required to have a soft diet because they were at risk of choking, and people who were at risk of falling had manual handling risk assessments in place to protect them from being hurt due to falls.

Care plans were well maintained, easy to follow and information was reviewed monthly or more frequently if needs changed. For example someone was having frequent falls and guidance from the falls clinic was clearly documented.

People's health care needs were being met. People were registered with a local GP who visited the home weekly. Visits from other health care professionals for example care managers, chiropodist, dentist, and optician also took place.

People had sufficient food and drink to keep them healthy. We saw lunch was well organised and people had the choice of meals. There was sufficient staff support available for people who required help to eat. Where people had an identified risk in relation to nutrition this was managed well by staff.

There were enough staff working in the home to meet people's needs. People said the staff were very good and they did not have to wait too long when they required assistance. We saw several examples of staff responding to call bells in a timely way throughout the day.

Staff recruitment procedures were safe and the employment files contained all the relevant documentation and safety checks to help ensure only the appropriate people were employed to work in the home.

The activity coordinator showed us the activity arrangements in place. People were engaged in activities in the lounge during our visit.

People had been provided with a complaints procedure and knew how to make a complaint should they need to. Relatives told us they knew who to talk to if they had issues or concerns.

There were effective quality assurance systems in place to monitor the service being provided, for example reviews of care plans, risk assessments, and health and safety audits.

The home was being well managed. People, relatives and staff said they found the registered manager approachable and available. Staff told us they felt valued and feedback from people about the quality of the service was positive.

Records relating to the care and treatment of people were stored securely and maintained accurately.

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 always safe.

People did not always receive their medicines safely and according to their medicines plan.

There were enough staff available to safely meet people's needs.

Risks to people were managed well and staff were aware of the assessments in place to help prevent avoidable harm.

Staff had a clear understanding of how to protect people from the risk of abuse and the procedures to follow if abuse was suspected.

Is the service effective?

Good

The service was effective.

The provider and staff had a good understanding of the Mental Capacity Act 2005. Deprivation of Liberty (DoLS) authorisation were in place for people who required these.

Staff had the appropriate training to meet people's needs and received adequate supervision to ensure they had the skills required.

People's health was managed well and they received adequate nutrition and hydration to maintain this.

Is the service caring?

Good

The service was caring.

People were involved and encouraged in decision making.

People were treated with dignity and respect and were responded to promptly when they needed help.

Privacy and dignity was maintained.

Staff spoke with people in a polite and kind way and they were looked after by a staff team who were caring and kind.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

People's concerns and complaints were listened to and responded to according to the complaints procedure in place.

Summary of findings

People were encouraged to participate in activities either in groups or individually.

Is the service well-led?

Good 

The service was well led.

The registered manager and staff had a good understanding of the service's aims and objectives and the needs of the people who lived there.

Staff felt supported by the registered manager and were encouraged to develop their skills further.

There were effective quality assurance processes in place to monitor the service. People and stakeholders were asked for their views on how quality could be improved

Bolters Corner 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 was an unannounced inspection, which took place on 29 October 2015. The inspection team was made up of two inspectors.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider in the form of notifications and safeguarding adult referrals made to the local authority. A notification is information about important events which the service is required to send to us by law.

We spoke with 5 people who used the service, seven relatives, nine staff which included the registered manager, the head of care and the activities coordinator. We also spoke with two health care professionals. We looked at five care plans, five risk assessments, four staff employment files and records relating to the management of the home including audits and policies.

Not everyone was able to communicate with us so we spent time observing the interactions between people and staff. We also spent time in the lounge and dining areas observing how care and support was provided.

The last inspection of this home was on 27 November 2013 where there were no concerns identified.

Requires improvement

Is the service safe?

Our findings

People who were able to said they felt safe living at Bolters Corner. A relative said “I am so relieved I found this home for my husband it is a marvellous place.” Another relative told us they had no concerns regarding the service and if they did they would be the first to air their views. Another relative said “We are just like one big happy family.”

Whilst people and relatives told us they felt safe there were concerns identified in relation to the administration of medicines. There was a policy in place for medicines administration and staff who undertook medicine administration had signed this policy to confirm they had read and understood this. The head of care had overall responsibility for medicine administration in the service. Medicines were stored safely in a trolley and store cupboards in a dedicated medicines room which was kept locked. A fridge was available for medicines that had to be stored below room temperature, for example insulin, eye drops and creams. We noted two items of medicine stored in the fridge were either out of date and some belonged to a person who was no longer in the service. Some had no opening date for creams, lotions and suspensions as to when they were started, which meant people could be given out of date medicine.

The service used the medication administration record (MAR) chart to record medicines taken by people. We noted appropriate codes were used to denote when people did not take their medicines. For example if they refused or if they were in hospital. However we also observed some unexplained gaps in administration records. The MAR charts included information about people’s allergies, a photograph for identification and if they required PRN (when required) medicines. We did not see evidence of PRN protocols in place. The majority of medicines were administered using the monitored dose system which were supplied by a local chemist that also undertook audits of medicines in the home and the provider actioned any comments from the audit.

We recommend that the provider review their medicine administration procedures with regard to dating medicine when opened, accounting for gaps in MAR charts and ensuring protocols are in place for PRN medicines.

Staff told us they would recognise the signs of abuse and were aware of the various types of abuse. They said that if they felt uncomfortable about how someone was being treated or if they suspected that abuse was taking place they would talk to the registered manager immediately and were confident that they would act on their concerns.

There was a safeguarding policy in place that provided staff with guidance to follow and all staff had read this policy. They told us they had undertaking training on safeguarding people from abuse and would know who to report this to if the manager was not available. For example the local authority who are the lead agency for safeguarding. We spoke with staff individually during our visit and they had a clear understanding of their roles and responsibilities to keep the people they cared for safe.

The staffing levels in the home were calculated using a dependency tool which provided the manager with the number of care hours required in order to meet people’s care needs. We looked at the duty rotas for the previous four weeks and saw the allocated number of staff on duty was sufficient to meet people’s needs. There were two qualified nurses and seven care staff on duty during the day and one qualified nurse with three care staff during the night. The registered manager was not included in the allocated staff numbers. Unexpected sickness or absence was covered by a team of dedicated bank staff to ensure the care provided was not affected. There were also other staff employed to help support people such as housekeepers, catering staff, activity coordinators, maintenance staff and laundry staff.

One person told us there were enough staff available to care for them and meet their needs. One relative said "There are always enough staff here and they look after my relative well. “ Relatives told us staff were attentive and nobody had to wait long for assistance. A health care professional told us they thought that the service was well staffed and that people looked comfortable and well cared for when they visited. We saw several examples of good practice throughout the day when call bells were answered promptly. This meant people did not have to wait for assistance.

There was a safe recruitment process in place and the required checks to ensure people were of good character and suitable to work with people were undertaken before staff started work. We looked at staff employment files and noted that staff had been recruited safely. This included two written references, a past employment history, and a

Requires improvement

Is the service safe?

satisfactory Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People had risk assessments in place for identified risks. Plans were drawn up with guidance for staff to follow in order to keep people safe. For example one person was at risk of choking and had a management plan in place to reduce the risk. This included soft food and thickeners in their drinks. When we spoke with staff they were able to tell us the action they would take in the event on a person choking.

Another person was at risk of developing pressure ulcers. We saw they had a Waterlow score risk assessment which is a tool used to assess people's skin integrity in place and guidance for staff to help prevent this occurring. We saw risk assessments in place for people who were at risk of falling and the management plans that needed to be followed to reduce the risk. Staff were able to demonstrate to us their understanding of the risks to people they cared for and what they needed to do when providing care to help keep people safe and well.

People's risk assessments were reviewed monthly or more frequently if an additional risk was presented or people's needs changed. Updated information was recorded and shared with staff and health care professionals to promote good practice.

The service had arrangements in place to provide safe and appropriate care through all reasonable foreseeable emergencies. The service had emergency contingency plans in place should an event stop part or the entire service running. Both the manager and the staff we spoke with were able to describe the action to be taken in such events.

Good

Is the service effective?

Our findings

People were supported by staff with the skills and training required to meet their needs. One person said "The staff look after me very well." Another person said "I like it here." A relatives said "This is a good home we are all like one big happy family." Another relative said "My relative has been here for a few years and not only do they care for them very well they are also a huge support to me."

Staff told us they had undertaken induction training when they commenced employment and were assessed as competent before they worked unsupervised. We looked at training records in place and saw that mandatory training which included manual handling, first aid, food hygiene, fire safety awareness, health and safety, dementia awareness and infraction control was undertake by staff as part of their ongoing development. Staff were supported to undertake further training for example a certificate or diploma in social care.

Staff had also undertaken training in caring for people living with dementia. The registered manager told us this was over and above the mandatory training so staff would able to support people they cared for. We observed a person who became a little agitated and restless following lunch and wanted to go home. A member of staff was able to engage that person in conversation regarding a previous interest and gradually reassure them that their relative would be along shortly to visit them. The member of staff told us it was the training they received that provided them with the skills to support people who get a little confused and "muddled." A relative told us that staff understood their family member so well and were able to manage difficult behaviour when required to.

Staff told us they had regular supervision and we saw documentation in staff files that this took place. They said during supervision with their line manager their strengths and weaknesses were discussed and they were given the opportunity to address issues or concerns as a result.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The registered manager was aware of the changes in DoLS practices and had policies and procedures regarding the Mental Capacity Act (MCA) 2005 and DoLS.

We saw evidence the service had assessed people's mental capacity (MCA) and held best interest meetings prior to applying for a deprivation of liberty safeguards authorisation (DoLS). People who required DoLS authorisation had an application submitted to the local authority to ensure that people were not having their liberty restricted inappropriately. This demonstrated the provider understood the legislation and its requirements.

People who were able told us they liked the food. They said they had plenty of choice and if they still did not like what was offered there was always an alternative. We observed lunch being served in the dining room. Tables were nicely laid with table cloths, drinking glasses, condiments and cutlery. A selection of juice and water was also available.

A relative told us they visited every day to support their family member with lunch. "This is my choice and not because I have any doubts about my relatives meals." They said "The food was homemade appetising and wholesome, and plenty of it." They told us meal times were a relaxed and friendly.

Food was served by the chef from a heated trolley and people were shown the choice available to help them choose what they liked. Special diets for example soft or pureed food was presented well and we saw people who required support with eating were given this by staff who sat with them in the dining room and ensured people had time to enjoy their food. A member of staff explained how people were encouraged to maintain their independence and said they used a special aids and a plate guard so people can continue to eat by themselves which was important to them.

Some people were at risk of losing weight and as a result there were Malnutrition Universal Screening Tools (MUST) in place so that the risk could be managed. People's weight was monitored regularly and recorded in their care plan so that appropriate action could be taken should they lose weight. The service had access to a dietician and speech and language therapist for further guidance when this was required.

People's healthcare needs were managed well. People had regular access to chiropody, dental care and eye care and visits were arranged accordingly. We saw that everyone was registered with a local GP who visited the service weekly or more frequently if required to do so. People told us they

Good

Is the service effective?

could see the doctor when they needed to and if they required additional support. For example consultant intervention or psychiatric support which was arranged by their GP.

We had the opportunity to talk with two visiting health care professionals during our inspection and we received positive feedback regarding the care provided. One healthcare professional said “This is a good home and I have no worries here.” Another said “The service is always welcoming and staff are caring and kind.” Relatives told us they were more than satisfied with the health care provided and any time there was a change to treatment or medication they were kept informed. They said they were able to ring at any time for an update and could arrange to see their relative’s GP if they found that was necessary. A relative said “When the time comes that I have to use a home I hope my family would choose this one for me.”

Good

Is the service caring?

Our findings

People told us they were very happy living in the service and that staff were kind and compassionate. One person said "The care staff are very nice." A relative said "The care is outstanding here." Another relative said "Every time I come the staff are always very pleasant and offer cups of tea." A health care professional said "the staff are genuinely caring."

We were able to see from observations and from our interactions with people that they were content living in the service. Staff were interacting with people in a trusting and caring manner. We saw staff gave people time and space to speak. Staff used signs, gestures, and body language to communicate with people and did not rush people to respond to questions, demonstrating an understanding of the individual and their communication needs. For example when people were choosing what to eat or when they required the bathroom it sometimes took several attempts with different styles to make themselves understood and staff were supportive of this.

Staff provided care and support in a kind and caring way and had time to spend with people individually helping them with specific needs. We saw a member of staff greeted a person with a thumbs up sign and waited for a smile and continued to chat in a cheerful manner for a few minutes before greeting another person. A relative told us that the atmosphere in the home was cheerful and caring. They said "Staff are cheerful all the time and nothing is too much trouble for them."

Staff had positive relationships with people they supported. A relative told us the staff "knew their family member well and took good care of them."

We saw people were well cared for and wore appropriate clothing that was clean and fresh. They wore appropriate footwear that fitted safely and their hair was neatly styled. A member of staff told us it was important that people look nice and wore nice clothes. People could visit the hairdresser during their weekly visit to home.

People's privacy and dignity was respected. We saw staff knocked on people's doors and waited for a reply before they entered which helped maintain people's dignity. Staff addressed people appropriately by their preferred name. Personal care was undertaken in bedrooms or bathroom in private.

There had been bereavement the previous evening and we heard relatives asking the manager to convey their condolences to the family. They wanted to send messages of sympathy and they told us "We are like an extended family here,"

People were encouraged to bring ornaments and photographs into the home to make their bedrooms more personal to them. Relatives and staff supported people to personalise their individual space. Relatives told us they were welcome in the home at any time and encouraged to participate in organised events and care reviews. They said there were private areas where they could visit their family member and speak without being overheard.

People were encouraged to make choices about their daily routines. Other people had to relay on relatives to help them make choices. For example some people chose to spend time alone while other people chose to sit in the lounge and to participate in activities they liked. A relative said their family member had a bath now due to mobility needs, and this had been discussed and the reasons explained in full.

End of life arrangements had been discussed with relatives and the multidisciplinary tram. We saw that advanced care plans were in place where appropriate and these were amended and updated regularly with input from other health care professionals. The registered manager told us the service worked closely with other disciplines for example hospice nurses and the GP regarding end of life support. There were facilities for relatives to spend a night in order to be close to their loved one when appropriate.

Good

Is the service responsive?

Our findings

People had assessments undertaken before they were admitted to the service in order to ensure there were the resources and expertise to meet people's needs. People were able were involved in their assessment as much as possible and were supported by a relative if appropriate. Relatives told us they had been involved in part of the assessment especially with their family member's life history which helped build a picture of what the person was like. They said they were asked questions about where their family member was born, where they went to school, their job and family life so that staff could get to know the person and build a picture of them.

The assessments we looked at were informative and explained the needs of the person which included areas such as communication, personal background, likes and dislikes, their physical health needs, cognitive ability, their mobility status, their dietary needs and information about their family and friends.

Care was person centred and individual. We looked at the care plans in place. These were written on information gained from the needs assessments and were detailed and informative. Each care need was supported with an action plan and objectives to be achieved. For example if someone was able to walk unaided, if they required the assistance of one or two staff or if they required a hoist to move them safely. Another person's care plan identified that they were at risk of choking and written guidance was in place for staff to manage this. Care plans were reviewed monthly or more frequently if needs changed.

We observed daily notes recorded not only the care and support being provided but included the person's mood, any comments they had made during the day and social activities they had been involved in. They also recorded visits from family and health care professionals.

The service was responsive to the needs of people. For example specialist chairs were provided to enable people who would normally be bed bound to spend time in the communal areas of the home. Profile nursing beds and air mattresses were also provided to help reduce the risk of pressure ulcers for people who were at risk of developing these. The service was also responsive to the need of a person to allow their dog to live in the home with them. The service also provided a mini bus for recreation and a car to take people to appointments and other engagements.

On the day of our visit we spoke to the activities coordinator who was undertaking a music and movement class in the lounge. This was well attended and people were supported by staff and relatives to participate. We saw a programme of activities displayed in the service These included music for health, board game, biscuit making, "finishing lines", and reminiscence including old films and events. A relative told us they supported their family to take part in the flower arranging activity which they enjoyed. For people who chose to spend their time alone one to one activities were arranged. For example reading aloud, hand massage and aroma therapy. The service had two daily newspapers delivered for group activity and some people arranged their individual newspapers for their own use.

People's spiritual needs were observed and visits form various clergy were arranged on request. A church service was organised on the first Friday of every month which also included Holy Communion for people who wished to attend. One person said they enjoyed attending religious services and were particularly looking forward to the Christmas Carols and service.

People knew how to make a complaint or comment on issues they were not happy about. People and their relatives were provided with a copy of the complaints procedure when they moved into the home. There was also a copy of this displayed in the main entrance. People would have to rely on staff or relatives to make a complaint on their behalf. Relatives told us if they were not happy about something they would talk with the registered manager who would solve any issues immediately. They said they had never used the formal complaints procedure. We looked at the complaints record and saw there were no complaints received this year.

Good

Is the service well-led?

Our findings

The home was being managed well by the registered manager. They had the support of the head of care in the day to day management of the home. People were happy about the management arrangements in the home. Relatives felt the service was well managed and they could talk with the registered manager every day and they were listened to. We saw the registered manager operated an open door policy and was visible throughout the home talking to people, staff and relatives Everyone we spoke to confirmed they were able to talk with the manager in their office at any time. Relatives told us the manager kept them informed regarding any changes in their family members care or treatment and they were able to ring the home and visit at any time. A health care professional said the manager was proactive and worked well with other health care professionals.

Staff felt supported by the management arrangements that were in place and said the registered manager was approachable and listened to any concerns or suggestions they had that might improve the service for people. We saw several occasions during our visit where members of staff were seen in the office discussing various issues concerning people with the registered manager with positive outcomes. For example if a person required the intervention of a health care professional and this was agreed.

We saw minutes of residents and relatives meetings that had taken place. This provided people or their relatives with an opportunity to air their views about a range of things. For example menu planning and activities. A relative said that the meetings were good and gave them the opportunity to meet other people in the same situation as them and to share how they felt. These meetings were also used to keep people up to date with any changes within the service and to keep them informed of forthcoming events and functions.

The provider had effective systems in place to monitor the quality of the service. The registered manager discussed issues with the housekeeper and chef to monitor the service provision and to plan ahead. For example when a room may require a deep clean before a new admission or when menus required to be changed according to the season.

Regular clinical meetings took place to monitor and review the standard of care provision and make improvements or amendments when required. For example when people had to attend external appointments arrangements were made in advance for additional care staff to accompany them as not to impact on the provision of care for other people in the service.

The standard of record keeping was generally good and up to date. Records were kept securely so that personal information was kept confidential. . Care plans and medicines records were kept locked when not in use. Reviews of care plans and risk assessments were undertaken in a timely way which meant staff had the most recent information and guidance in relation to individual's care.

Health and safety audits were undertaken to maintain the health and welfare of people and visitors to the service and to promote a safe working environment. During our visit we saw evidence the provider ensured equipment used in the service was safe and regularly serviced. We saw checks on gas, electricity, legionella, lift servicing and fire equipment were undertaken at least annually.

Audits of infection control and of accidents and incidents were undertaken and evaluated to measure the service being provided. Issues identified were discussed at service meetings.

People, their relatives and stakeholders were asked to complete customer service satisfaction questionnaires to give feedback to the provider regarding the service they received. We looked at a sample of these questionnaires and saw people were happy with the staff and the care provided. Relatives said their family members were treated with kindness dignity and respect. They said the service was clean and hygienic. They said the staffing levels were satisfactory and "I have nothing but praise for the service." Stakeholders said the service was proactive in making referrals and the care was good. They said there was little to worry about here and the staff were genuinely caring.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The provider continued to inform the CQC of all significant events that happened in the service in a timely way. This meant we are able to check that the provider took appropriate action when necessary.