Bupa Care Homes (ANS) Limited

Meadbank 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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

We conducted a comprehensive inspection of Meadbank Nursing Centre on 4 and 5 April 2016. At this inspection a breach of regulations was found in relation to the safe management of medicines. After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to this area. We conducted a focussed inspection on 2 September 2016 to check the provider had followed their plan and to confirm that they now met legal requirements in relation to the breach found. We also followed up some information of concern that was received prior to the inspection. We found improvements had been made in line with the provider's plan and we did not identify any concerns in relation to the information of concern.

We undertook this focused inspection in July 2017 to follow up some information of concern which we received about the care of people using the service and potential neglect. This report only covers our findings in relation to the above. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Meadbank Nursing Centre on our website at www.cqc.org.uk.

Meadbank Nursing Centre is a care home with nursing for up to 176 people, with a particular emphasis on providing palliative care. There are four units at the home each named after a famous bridge in London and each unit was supposed to have its own unit manager. At the time of our inspection, one unit had a recently recruited unit manager and another unit did not have a unit manager in place although the service was recruiting to fill this vacancy. Albert Bridge unit which is based on the ground floor is home to older people with some early onset dementia and Westminster Bridge unit which is on the first floor is a nursing unit. Chelsea Bridge unit which is located on the second floor is home to those with palliative care needs and Lambeth Bridge unit is home to those with advanced dementia needs. There were 157 people using the service when we visited.

The service had a registered manager in place. 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.

Procedures were in place to protect people from abuse. Staff understood how to recognise abuse and knew what to do if they suspected abuse was taking place.

Risk assessments and care plans varied in quality and we found some examples of risk assessments and care plans that did not fully explore and manage risks to people's care.

At our previous inspection we found improvements had been made in relation to medicines administration. However, at this inspection we identified some concerns in relation to the safe management of medicines. We found medicines were not always stored appropriately. We found one fridge that was not working and therefore the medicines within it were not safe for administration and one controlled drugs cabinet was not

in place in line with legal requirements. We found some 'as required' medicines were not accompanied with sufficient instructions for nurses to safely administer them and we found two medicines with a reduced expiry date upon opening were not marked with the date of opening for staff to monitor how long they remained safe for use. We also found some expired medical devises were available for use.

There were enough staff employed and scheduled to work to meet people's needs and keep them safe.

People were not consistently supported to meet their nutrition and hydration needs. Food and fluid charts were used, but these were not consistently filled in. People were otherwise supported to maintain a balanced, nutritious diet. People were supported effectively with their health needs, but staff understanding of people's health needs was variable.

The provider was not meeting the requirements of the Mental Capacity Act 2005 (MCA). We found some examples of mental capacity assessments not being completed when they ought to have been.

People gave good feedback about care workers, but some people reported that their privacy was not always respected.

Accidents and incidents were reported as required. However, we did not see evidence of analysis of accidents and incidents and consequent action taken to minimise these.

Notifications were not always submitted to the Care Quality Commission as required. We identified one example of a notifiable incident not being reported when it ought to have been.

During this inspection we found four breaches of regulations in relation to meeting people's nutrition and hydration needs, the provision of safe care and treatment, the need for consent and the reporting of notifiable incidents. You can see what action we told the provider to take at the back of the full version of the report.

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 some concerns in relation to the safe storage and administration of medicines.

The risks to people's physical health were not always identified and managed appropriately.

Procedures were in place to protect people from abuse. Staff understood how to recognise abuse and were aware of the provider's whistleblowing procedure.

There were enough staff available to meet people's needs and we found that recruitment processes helped to ensure that staff were suitable to work at the service.

Is the service effective?

Requires Improvement

The service was not consistently effective. People were not consistently supported to meet their nutrition and hydration needs. Fluid and food charts were in use where people required monitoring of their needs, but these were not consistently filled in.

People were supported to maintain good health and were supported to access healthcare services and support when required, but not all care staff were fully aware of people's needs.

The service was not always meeting the requirements of the Mental Capacity Act 2005 (MCA). We saw some examples of mental capacity assessments not being completed when they ought to have been.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us their privacy was not always fully respected.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. A number of audits

were carried out by the registered manager and other senior managers within the organisation. However, these did not adequately address the gaps we identified in records and the issues in relation to risk assessments and care plans.

We identified one example of a notifiable incident that had not been reported to us as required.

Meadbank 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.

We undertook an unannounced focused inspection of Meadbank Care Home on 10, 11, 12 and 13 July 2017. This inspection was completed in response to some information of concern we received about the care of people using the service. The team inspected the service against four questions we ask about services. Is the service Safe? Is the service Effective? Is the Service Responsive? Is the service Well Led?

The inspection was conducted by five inspectors, three experts by experience, a pharmacist inspector and a specialist adviser. The three experts by experience attended on the first day with two inspectors, the specialist adviser attended on the first and second day, the pharmacist inspector attended on the second day with four inspectors and one inspector attended on the third and fourth days of the inspection. The specialist adviser was a nurse with expertise in dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

The first day of the inspection was unannounced. We told the provider we would be returning for the subsequent three days.

Prior to the inspection we reviewed the information we held about the service, including any notifications about serious incidents and any changes to the service. During the inspection we spoke with 41 people using the service and 12 relatives. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We therefore used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help us to understand the experience of people who could not talk with us.

We looked at a sample of 31 people's care records and records related to the management of the service. We spoke with the registered manager, the area director, two unit managers, 12 care workers and three nurses.

Requires Improvement

Is the service safe?

Our findings

Prior to this inspection we received information of concern which related to some safeguarding incidents that had taken place within the home. These had been reported and were being investigated by the local authority. We spoke to people using the service about whether they felt safe in the home. People told us they felt safe using the service. Comments included, "Yes I feel safe", "I feel very safe here, staff do everything to help you" and "I am safe here. The staff look after me."

The provider had a safeguarding adults' policy and procedure in place. Staff told us they received training in safeguarding adults as part of their mandatory training and demonstrated a good understanding of how to recognise abuse. Staff knew how to report safeguarding concerns and explained the various signs of abuse and different types of abuse. Care staff and nurses were aware of the safeguarding incidents that had prompted our visit and knew about the current status of the local authority investigation. Care staff were aware of what action they were required to take if they suspected abuse was taking place and were aware of the provider's whistleblowing procedure. Whistleblowing is when a care worker reports suspected wrongdoing at work. A care worker can report things that are not right, are illegal or if anyone at work is neglecting their duties, including if someone's health and safety is in danger. We have been liaising with the local authority safeguarding team who were in the process of conducting their investigation.

Information about individual risks to people's welfare was included in an initial 'pre- admission' assessment. These covered numerous areas related to the person's physical and mental health, but the quality of these initial assessments was variable. Some initial assessments contained a detailed assessment of the risks associated with the person's care and prompted care staff to produce care plans that appropriately managed these risks. However, some initial assessments contained very limited information and only included ticked boxes in response to specific questions posed within the body of the form which meant that these documents did not always provide sufficient information for staff about how to manage risks.

The information within the pre-admission assessment was used to prepare care plans and risk assessments in specific areas of the person's care including moving and handling, nutrition and wound care. Each section began with an initial risk assessment which included standardised questions to help staff identify the specific areas of risk. The information from the risk assessment triggered the use of further assessments and tools which were then used to write the care plan.

We found there was some variance in the quality of the risk assessments and consequent care plans. We saw some examples of risk assessments which clearly identified the risks involved in the person's care and prompted care staff to produce specific care plans and seek professional advice. For example we saw one risk assessment which clearly identified that the person had a high risk of falls. We saw a care plan was in place to manage this, which included advice to care workers in how they were to minimise the risk of falls. When spoken to, care workers were aware of the risk to this person and knew that the person needed monitoring when they mobilised, required the use of a wheelchair for long distances and needed appropriate footwear.

However, two risk assessments and care plans did not appropriately manage risks to people and as a result exposed people to risk of harm. For example, we looked at one person's care record which included detailed advice from a Tissue Viability Nurse (TVN) about how to manage one person's pressure ulcer. However, these details were not fully incorporated in their care plan. For example, there was no mention within the care plan as to what pressure relieving equipment the person was supposed to be using. This placed them at risk of this equipment not being used. The person was also supposed to be moved every two hours as instructed by the TVN, but their care plan only recorded 2- 4 hourly turns. We found the person was often being turned fewer than every two hours as a result. We also found there was very little recorded information about the progress of the person's wound healing, but care staff did inform us that there had been some improvement in the person's condition.

We saw another example of a person who did not have an appropriate moving and handling care plan in place. We found the person was able to move themselves when in their bed, but their method of doing so was not risk assessed as being safe as they partially used their bed rails to manoeuvre themselves.

We discovered two examples of an inappropriate use of restraint on two different people when giving personal care. Care workers told us that when giving personal care to two people, one care worker would hold the person's hands down whilst the other delivered their care. This is so the person did not physically assault them. However, there was no indication on the documentation that this was an appropriate decision that had been risk assessed appropriately and was in their best interests. We spoke with the unit manager who spoke with staff immediately and explained that they were not supposed to do this. We also spoke with the registered manager who arranged appropriate training which was to be completed within 10 days of our inspection. She told us that staff were not supposed to use any form of restraint when supporting people.

The above issues constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified some concerns in relation to administering and storing medicines. Medicines were delivered on a monthly basis for each person by the local pharmacy. Medicines were stored safely for each person in a locked cupboard, but we saw one controlled drugs cabinet was not erected in accordance with legislation. We reported this to staff who ensured that this was corrected on the same day. Fridge and room temperatures were monitored and recorded on a daily basis.

We found that a number of people were prescribed PRN 'as required' medicines. For some people there was insufficient information for nurses to make a decision about how to administer these medicines, nor was there sufficient information to inform them about the expected outcome. When these medicines were administered there was no accompanying record to show that the person had been assessed as needing the medicines and there was also no record made of the outcome of the administration to demonstrate that these had been effective. This meant that we could not be assured that PRN medicines were being administered appropriately to meet people's individual needs.

We also observed two medicines where the manufacturer specified a reduced expiry date when opened, however we found these did not have the opening date recorded. This meant that the provider could not provide assurance that these medicines were safe and effective to administer at the time of our inspection. We also found a number of date expired medical devices and when asked, staff members told us that there was no regular checking of these products except at point of use. This placed people at risk of either having unsuitable equipment used on them or of equipment not being available for use.

The above issues constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.
We found Medicines Administration Record (MAR) charts had been completed correctly and people were receiving their medicines as prescribed. We saw that a daily checking audit had been put in place to monitor compliance with this. This meant that people were receiving their medicines as prescribed.

We saw copies of weekly and monthly checks that were conducted of medicines which included controlled drugs. This included a physical count of medicines as well as other matters including the amount in stock and expiry dates of medicines. The checks we saw did not identify any issues that we found.

Nurses had completed medicines administration training within the last two years. When we spoke with the nurses, they were knowledgeable about how to correctly store and administer medicines.
People using the service gave mixed feedback about whether they felt there were enough staff on duty to meet their needs. Their comments included, "You wait ages for them to come to you" and "The staff seem nice and friendly, they are just rushed off their feet."

However, despite these comments, staff told us they felt there were enough of them on duty to do their jobs properly. Their comments included, "We are actually overstaffed, it's just that some staff are not deployed properly", "We get enough staff" and "It's generally OK. We manage between us." The registered manager explained that senior staff at the service assessed people's needs on admission to determine what their level of dependency was in terms of care and support from nursing and care staff. Staff were then allocated to a particular unit and individual staff members were allocated to provide care to particular people. Each unit was staffed by two nurses and approximately one care worker for every six people except on the palliative care unit where there were additional staff as people's needs were higher. We reviewed the staffing rota for the week of our inspection and this tallied with what we had been told. Our observations of the number of staff on duty during our inspection also tallied with the rota.

Requires Improvement

Is the service effective?

Our findings

Prior to our inspection we received information of concern relating to one person's hydration levels. We therefore checked whether people were adequately hydrated on the days of our inspection. Where people were identified as being at risk of dehydration we saw forms were in place to record their fluid intake. However, these were not consistently filled in. In one unit we identified five examples of fluid intake records not being fully filled in. Some forms included gaps of six hours where people did not appear to have been offered fluids. We spoke with the nurse in charge who explained that people were given adequate fluids as they had seen this being done for some of the people with gaps in their hydration records, but they confirmed that this was not fully recorded.

People's care records included an 'eating and drinking' section which included risk assessments and a care plan that included information and guidance to care staff about people's dietary requirements and details about their likes and dislikes. We saw records that detailed people's nutritional needs and allergies. This included completion of a Malnutrition Universal Screening Tool (MUST) which identifies whether people are at risk of malnutrition or dehydration. However, we identified two examples where these records were either not properly filled in or incorrectly filled in. For example, one person's MUST assessment did not correctly score their level of risk. A senior member of staff later confirmed the correct score and referred the person to the dietitian as required. We found another person was being given a pureed diet. When questioned by the visiting dietitian, they were unable to confirm why they were being given this diet and could not confirm whether this was the correct diet the person needed. Therefore we could not be assured that people's nutritional needs were always appropriately met.

The above issues constitute a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA, and found that the provider was not always meeting the requirements of the MCA. Staff had received MCA training and were able to demonstrate that they understood the issues surrounding consent.

Care records contained a specific section entitled 'choices and decisions over care'. This included an initial risk assessment that prompted staff to undertake a mental capacity assessment in relation to specific decisions where this was needed. However, we found that assessments were conducted inconsistently and we found there were some examples where assessments were required and had not been completed. For example we found in two people's care records that their risk assessment concluded that they did not

require a mental capacity assessment to be conducted as they both had capacity. However, the same forms also stated that these people were unable to make complex decisions on their own and some decisions were made in their best interests. In another person's care record their care plan stated that they were unable to make decisions, but there was no mental capacity assessment to determine this. The care plan stated that the person's family and friends made decisions on their behalf. These examples meant the provider could not be assured that decisions were correctly made in accordance with people's valid consent or in their best interests in line with the MCA.

The above issues constitute a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found details of involvement from multi-disciplinary teams which included dietitians and speech and language therapists. Where referrals were required, we saw from records that these were appropriately progressed and advice was obtained and implemented. Where monthly monitoring was required, for example monthly weight checks, we saw this was done and recorded.

People had mixed views about the food available at the service. Comments included, "The food is alright", "The food is much better now", "The food is absolutely delicious" and "It's like school dinners." We spoke with the chef about the food available. They explained that they obtained feedback about the food from people using the service and catered for their preferences and cultural requirements. The chef was aware of people's specific healthcare requirements which included those people with diabetes. The chef altered the menu each month depending on the feedback received and we saw a copy of the menu for the month of our inspection. Food was seasonal and variations were made according to the season. We sampled the lunch on the first day of our inspection. The food was appetising, of a good portion and served at the correct temperature.

Care records contained information about people's health needs. The service had up to date information from healthcare practitioners involved in people's care, and senior staff told us they were in regular contact with people's families to ensure all parties were well informed about people's health needs. When questioned, staff had a variable understanding about people's health needs. For example, care workers were able to identify people's existing healthcare concerns however, on one unit, the unit manager was unable to provide up to date details about people's care needs when questioned by the visiting GP. Adequate observations were not recorded for some people and the GP had to wait for the arrival of another senior staff member to receive an adequate overview for another person.
Where required, bowel charts were in place for some people. However, in one unit we found bowel charts were not being filled in and this information was not available for the visiting GP. This meant the GP was unable to conduct a full review of the person in question to determine whether there were any issues regarding their elimination. The GP spoke with care staff about the importance of keeping these records and we were assured that these records would now be kept.

Requires Improvement

Is the service caring?

Our findings

Prior to our inspection we received information of concern relating to one person's dignity. People we spoke with gave mixed feedback about whether they felt their privacy and dignity was maintained and respected. Comments included, "I do feel I am treated with dignity and respect, they use my name, they are not rude", "They knock and come in. If I don't answer, they come in anyway" and "Privacy is hard here. They do knock, but don't give you much time to answer."

Care workers told us they promoted people's privacy and dignity and gave us examples of how they did so. Their comments included, "I'm very careful when I give personal care. I make sure they know what I'm going to do and I don't expose anything unless I have to" and "I always knock on people's doors before going in." We observed staff speaking with people with respect and knocking on doors before entering their rooms. However, we also heard care staff refer to people by their room number instead of their names when speaking with one another which is not a dignified manner of referring to people.

Requires Improvement

Is the service well-led?

Our findings

Numerous audits were conducted within the home including care plan audits. However, these were not consistently completed in every unit and did not identify the issues we found in relation to the inconsistencies in people's care plans and risk assessments. We were assured by the registered manager that all care plans would be reviewed again and updated within two weeks and she had assigned senior members of staff to carry out this task.

We saw records of complaints and accidents and incidents. We saw there was a process for reporting and managing these. The registered manager told us they reviewed complaints, accidents and incidents to monitor for trends or identify further action required. They told us accidents and incidents were also reviewed by senior staff within the organisation who also monitored the results for trends and made further recommendations where required.

We saw evidence of checks which were conducted across the home. The registered manager told us she completed a 'weekly walk round and take 10'. This was a daily observation of the running of the home and consequent feedback sessions to care staff about the results. The registered manager checked areas such as infection control and health and safety matters. We saw a copy of the standardised check list she used which included a detailed list of areas she checked. It included an improvement plan for further actions required and we saw these were in the process of completion. The registered manager also told us unit managers completed 'nightly checks' of the home which were recorded and reported and discussed with the Head of Care on a weekly basis. These included a record of the observations of the night staff in their performance of their work. Where concerns were identified, plans were put in place to rectify these.

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 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 11 HSCA RA Regulations 2014 Need for consent The provider did not always provide care in accordance with the Mental Capacity Act 2005. Regulation 11(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always assess the risks to the health and safety of service users receiving care or treatment and did not do all that is reasonably practicable to mitigate any such risks. The provider did not always ensure the proper and safe management of medicines. Regulation 12 (1)(2)(a), (b) and (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not always ensure the nutritional needs of service users were met 14(1).