Bupa Care Homes Limited

Sabourn Court Care Home

Inspection report

Oakwood Grove
Leeds
West Yorkshire
LS8 2PA

Tel: 01132658398

Date of inspection visit:
18 January 2017

Date of publication:
16 March 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 18 January 2017. Our last inspection took place on 29 September 2015 when we gave an overall rating of the service as 'Requires Improvement'. We found a single breach of the legal requirements in relation to the safe management of recruitment processes as relevant staff professional qualifications had not been checked.

Sabourn Court Care Home is registered for 49 places for older people. The home is comprised of two buildings. Oakwood House dates back to the 19th Century and Park House is a purpose built building. It is located close to local amenities and is accessible by public transport.

At the time of our inspection the service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. We found there was a manager in post who was in the process of registering with the CQC.

Risks to people had been assessed, managed and reviewed. Recruitment checks had been completed and relevant professional qualifications had also been checked and were regularly monitored.

The registered provider planned staffing levels using a dependency tool to ensure there were enough staff to meet people's needs and provided in excess of these assessed staffing hours. However, people and staff said there wasn't enough staff. People did not always feel safe during the night for this reason.

Although people were complimentary about staff, we observed several occasions when staff did not communicate with people and provide reassurance. We discussed this with the regional director. We found the atmosphere in the lounge was quiet and observed staff had limited time to chat with people between their daily routines. Privacy and dignity was being respected.

People and staff were not complimentary about the manager who they felt needed to have a stronger presence in the home. Quality management systems were found to be effective through a system of audits which had been regularly carried out. Feedback was actively sought from people and relatives.

Codes for keypads which provided access to sluice areas were written above these doors which meant people and visitors were able to access these areas. Building maintenance was up-to-date and fire safety checks had been regularly completed.

Medicines were mostly well managed as staff had received this training and had their competency checked.

Staff received supervisions and appraisals, although this was not as often as stated in the registered provider's supervision policy. Staff training records showed high levels of completion and staff received an

appropriate induction.

Staff understood the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards although recording of consent and best interests decisions needed to be clearer. Records we looked at showed people had access to a range of healthcare services.

People were satisfied with the food and drink and we saw most people had a positive mealtime experience. People gave mixed feedback about activities. Additional staff hours for activities had been approved by the registered provider and were beginning the recruitment process for this.

Care plans provided sufficient guidance for staff to follow in order to provide effective care. However, there was little evidence of involvement from people and relatives in reviews. Audits and action plans showed this had been identified by the registered provider as an area for improvement.

Complaints were appropriately managed as information on how to complain was on display and people knew how to complain if they were dissatisfied. Complaints were investigated and responded to. The service had received a high volume of compliments from relatives.

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.

The registered provider used a dependency tool to determine appropriate staffing levels. People and staff said there wasn't enough staff. People did not always feel safe for this reason.

Medicines were mostly well managed. Risks to people had been assessed and reviewed. Recruitments processes were safe.

Buildings were well maintained and fire safety checks were regularly carried out.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff understood MCA and DoLS, although recording of consent and best interests decisions needed to be clearer.

People had access to a range of healthcare services. People were satisfied with food and drink.

Staff received some supervisions and appraisals. Training completion levels were found to be high.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed several occasions when staff did not communicate with people and provide reassurance.

People were complimentary about the staff who provided their care. Privacy and dignity was respected.

There was limited evidence of people's involvement in creating their care plan.

Is the service responsive?

Good

The service was responsive.

Care plans were sufficiently detailed to meet people's needs. Reviews took place, although there was little evidence of people's involvement.

There was an activities programme and we saw activities taking place. Additional staff hours for this had been agreed.

Complaints were well managed.

Is the service well-led?

Requires Improvement

The service was not always well led.

People and staff were not complimentary about the manager who they felt needed to have a stronger presence in the home.

People were able to feedback about this service through meetings and satisfaction surveys.

A number of audits carried out by the manager and regional director we carried out on a regular basis.

Sabourn Court Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 18 January 2017 and was unannounced. The inspection team consisted of two adult social care inspectors, a senior qualitative analyst and an expert-by-experience with a background in nursing. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

At the time of our inspection there were 33 people living in the home. During our visit we spoke with the manager, the regional director and a further seven members of staff. We also spoke with 13 people and one visitor. We spent some time looking at the documents and records that related to people's care and the management of the service. We looked at five people's care plans.

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

Before our inspection, we reviewed all the information we held about the home. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we rated this domain as requires improvement. We found a breach of the regulations as the registered provider had not recorded checks on relevant professional qualifications to ensure staff were suitably qualified. At this inspection we saw this had improved.

The manager showed us a matrix which demonstrated all relevant professional qualifications had been checked and were up-to-date. We looked at the recruitment records for three staff members. Appropriate checks had been completed before staff worked unsupervised at the home which included taking references and records of Disclosure and Barring Service (DBS) checks. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members were not barred from working with vulnerable people.

We looked at whether people were safe receiving this service. One person said, "They are caring, but I bruise easily and I have to keep telling them that I do and to be gentle, the majority of the carers are fine it's just the odd ones." Staff we spoke with had received safeguarding training and were able to describe how they would recognise and report abuse. One staff member told us, "There is a 'speak up' policy that we're all aware of." This meant staff knew about the registered provider's whistleblowing policy. 'Whistleblowing' is when a worker reports suspected wrongdoing at work.

People felt secure living at this service, although they did not always comment positively about feeling safe due to concerns with night time staffing levels. One person said, "I feel safe definitely as there is security and lights at night. However, it's not always a good night shift. A bit inadequate as sometimes it's one of our staff and an agency person only." Another person said, "I try not to be too demanding. They don't always come as needed, then say don't worry if I have an accident. I think they don't have enough staff and you can tell sometimes by the atmosphere, I'm not neglected it's just the situation, but it seems worse at night."

People and staff both told us there were not enough staff. One person said, "Staff are too busy and I have to wait long times sometimes." People told us they knew how many staff should be on shift and felt anxious when there was less than needed. The manager told us they had recently filled a long standing vacancy on the night shift.

Staff also said there were insufficient staff on shift. One staff member said, "We really need more people on. Quite often we work short." Another staff member said, "I don't think there's enough. The interaction is sometimes cut short." Another staff member who said there wasn't enough staff commented, "Residents like you to sit with them. A lot of them like that time." We discussed this with the regional director who told us people's care needs were being met and we saw evidence which confirmed this during our inspection. We observed occasions when staff took time to sit down and talk with people, although these opportunities were limited due to a lack of available staff time.

The registered provider planned staffing levels using a dependency tool to ensure there were enough staff to meet people's needs. The dependency tool used information about individual people who used the service,

based on care and nursing needs. We looked at the output of the dependency tool for December 2016 and compared this to rotas for the same period. This indicated the home was being staffed above requirements. The manager told us the dependency tool calculation was due to be updated the week after our inspection. The registered provider's PIR stated; 'We will continue to use the corporate dependency tool monthly in order to provide assurance that staffing levels are appropriate to meet the needs of the residents'.

We looked at two full days of call bell response times from January 2017 and saw the majority of these were responded to inside two minutes. There were some very occasional exceptions where people had to wait longer.

The manager told us they were using agency staff between 22 and 44 hours per week. They said they wanted to increase the number of bank staff, so they were able to cover more shifts in house when they experienced staff absences. We saw this had been discussed at the September 2016 staff meeting.

We looked at the management of medicines and found this was mostly safe. Medicines were stored in lockable areas where room and fridge temperatures were regularly recorded. We looked at four medication administration records (MARs) and found these were mostly completed. One person who required medicine for Parkinson's Disease was seen to have missed doses on the mornings of 3 and 18 January 2017. We discussed this with the regional director who counted the stock held and determined these medicines were given, but not recorded. They told us they would look at this.

Controlled drugs (CDs) are medicines liable to misuse which need to be secured appropriately. We found stock held of CDs balanced the records in the register which was signed by two staff for each administration. Protocols for medicines prescribed 'as and when required' were in place. This meant staff had guidance to follow so they knew when it was appropriate to offer these medicines.

A weekly medication audit was used to identify any gaps in recording the administration of medicines. Any gaps were followed up using an incident reporting form which detailed action taken in response. Medication errors had been appropriately responded to through additional staff training and competency checks. All staff responsible for medicines had received this training.

We looked in detail at five people's care plans. Risks associated with their care and support needs were appropriately assessed, managed and reviewed. Areas considered included oral care, nutrition, falls, behaviours that challenge, moving and handling, skin integrity and use of bedrails. We saw risk prevention measures were in place where these were required. For example, one person who was at risk of developing pressure sores required checks to ensure they were repositioned regularly. We saw evidence these checks were undertaken at the required frequency and confirmed the person was assisted to change position when necessary.

We found codes for sluice doors were listed above the entrance to these areas which meant people and visitors may have been able to access these rooms.

We saw personal emergency evacuation plans were available for staff to refer to in the event of a fire. Information on what to do in the event of a fire was on display. Testing of electrical equipment had been completed in July 2016 and gas and electrical safety certificates were also up-to-date. We saw evidence of monthly checks which included, for example, fire alarm testing, emergency lighting, call buzzers, lifts, hoists and water service. Fire evacuation practice had taken place as recently as August 2016.

We reviewed accident and incident records, and records relating to any incidents which had been referred to

the local authority as safeguarding matters. The manager added notes and actions to accident and incident reports, showing they had reviewed them. We saw actions to protect people involved were taken as required.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Care plans we looked at contained capacity assessments for a range of areas of people's care and support. These covered all care plans in place for the person, including safety, moving around, mental health and wellbeing and choices and decisions over care. The capacity assessment used a four stage test which measured the person's ability to understand, retain and review information relating to the decision and a statement as to whether they had capacity to make that decision. For each care plan area there was an indication of the person's capacity, for example 'has', 'lacks' or 'variable' together with evidence to support that outcome.

Where people lacked capacity there was an inconsistent approach to best interests decisions. For example, one care plan we looked at contained a record of a best interests decision for a flu vaccination which had involved family, and a decision for the use of bed rails which had only involved staff. A best interest decision for use of bedrails was documented in another care plan and showed family of the person had been involved. We raised this with the regional director during the inspection.

Consent was not always documented clearly in care plans. Some care plans contained an indication that consent would be implied by the person for areas of care including medicines, medicinal tests, photography and personal care. We spoke with a staff member about this and visited a person for whom this was relevant. The staff member told us the person did not communicate verbally, but would respond by moving their head away to withdraw consent, for example when food or medicines were offered. They said, "[Name of person] is the boss. They will let you know what they want." We saw this advice was documented in the person's care plan.

In some care plans we saw consent documents had been signed by either the person or their representative, for example for sharing confidential personal information with health, social care and regulatory professionals. In one care plan we saw this had been signed by a member of staff with a statement this had been done 'in [name of person]'s best interests.' There was no documented best interests decision in the care plan.

Staff we spoke with told us they gave people choices on a daily basis. They said if anyone refused care they

would respect their choice and discuss this with the nurse. One member of staff commented, "We don't force anyone to do anything."

The manager told us DoLS had been applied for as required, however, at the time of our inspection none of the applications had been authorised. We saw copies of applications in care plans, and saw these had been appropriately made.

Most people we spoke with told us they thought staff were sufficiently skilled to meet their needs, although one person with a specific health condition felt staff didn't understand this. One person said, "Staff are well trained, I just feel they know naturally how to do things."

The manager told us staff were scheduled to receive six supervisions per year. The records we looked at showed supervisions took place, although not as frequently as described. Evidence of staff supervision records showed these were sufficiently detailed. The manager told us they wanted nursing staff to take on more responsibility for carrying out supervisions and said appraisals would be carried out over the two months following our inspection.

We looked at staff training records and saw high levels of completion. We asked staff how their knowledge and understanding was checked after training. One staff member told us, "Every time I've had training there's been a test at the end of it."

We observed the lunchtime experience. The dining room was well laid out with tables nicely set with menus and place settings, although people could choose if they wanted to eat in their own room. People were offered more food and drinks.

One person told us they could choose what to have for breakfast. People were satisfied with their meal choices and the quality of food provided. The registered provider's December 2016 satisfaction survey showed 70 per cent of people were satisfied with food. The manager told us they used the registered provider's standard menu, but said they were able to vary from this if needed. They told us, "There's always an alternative." People had access to drinks throughout the day of our inspection.

We saw people's level of nutritional risk was regularly reviewed, with their weight being recorded monthly. Where there was evidence people were or had been at nutritional risk we saw appropriate action had been taken. Care plans were updated, weights were taken more frequently and input from health professionals such as GPs and dieticians had been sought. In one person's care plan we saw their nutritional risk had been reduced as a result of the health professionals' advice being adopted into their care plan.

Records in people's care plans showed they were supported to access a range of health and social care professionals in order to maintain good physical and mental health. These included; GPs, district nurses, tissue viability nurses, dieticians, speech and language specialists, social workers, mental health teams, dentists and opticians.

Requires Improvement

Is the service caring?

Our findings

People we spoke with said they were cared for by staff. Comments included; "People are very kind. I'll tell them if there's a problem", "It's a good place, above average. If I was to move, I doubt I could find anything better", "I don't like to go out of my room much and I get what I want. I only have to ask", "Yes, in the main they are caring" and "Some brilliant staff. Feel staff are our family." One relative said, "They look after her well. They care for her alright and I know that she's being looked after."

We observed different practices in how well people were cared for by staff. For example, there was a clear rapport between one staff member and a person who was preparing for their morning bath. However, we observed one person being brought into the lounge in a hoist by two members of staff. They assisted this person into an armchair and placed a cardigan on them. Throughout this period staff did not talk to the person they were assisting which meant they had not explained what they were doing to provide reassurance. At lunchtime we saw a staff member approach a wheelchair user from behind and moved the person backwards ready to wheel them into the lounge without communication. We observed two people who required assistance with their meal. One member of staff assisted the person, provided encouragement and chatted to them throughout the meal. Another member of staff started to assist, but left the room without communicating they were leaving. The staff member returned a couple of minutes later and apologised and then proceeded to help the person. We saw two other examples where staff did not interact with people they were assisting through moving and handling. We discussed this with the regional director.

The atmosphere in the lounge was quiet and the television was on, although this was difficult to hear and there were no subtitles.

We found a number of staff members who had worked in the home for several years. The manager told us, "The staff group is extremely stable." Staff we spoke with were able to describe the people they cared for and were familiar with their care preferences.

People's care plans lacked evidence they or their representatives had been involved in writing them. Where there was space on documents to record who had been involved and what their input had been we saw this was routinely not filled in. The manager told us they had identified this prior to our inspection. They said, "I think that's ongoing. We do need to formally capture that better."

Care plans contained information about people which staff could use in order to build relationships with them. This included information about the person's career, holidays, pets, significant life events and important family members and friends. There was also information relating to whether the person wished to vote in elections, maintain religious, spiritual or cultural practices, hobbies and their likes and dislikes. The manager told us people's spiritual needs had been supported with religious leaders having visited. They told us written information could be produced in larger formats if needed. The manager told us, "It's a pretty non-diverse resident group."

Staff we spoke with knew how to protect people's privacy and dignity. One person said, "The staff are very

respectful. Another person told us, "Respect, well mostly. However, there are some that don't." The registered provider's December 2016 satisfaction survey showed 80 per cent of people felt their privacy and dignity was respected. We saw staff asked people if they wanted their room doors opened or closed and called in to the person if the door closed to check if they needed anything. We saw people rooms were personalised based on their interests and individual tastes.

Good

Is the service responsive?

Our findings

We saw the registered provider undertook an assessment of people's needs before they started using the service. A series of care plans were developed based on the pre-assessment, and we saw these included both standard care plans and individual care plans to ensure specific needs were met. Standard care plans included those for senses and communication, lifestyle, safety, skin care, wound care and eating and drinking. We saw individual care plans for the management of behaviours that challenge and use of controlled medicines.

Care plans were reviewed monthly, and we could see notes as to what had changed or why there had been no change as appropriate. We did not see evidence of people or their representatives being involved in this process. We discussed this with the manager during the inspection. They told us this would be linked to the resident of the day initiative, and was an area they had already identified for improvement. We saw audits and action plans which showed this had been discussed.

Daily notes were kept for each person which confirmed their care needs had been met and other details about their day, such as changes in behaviours or refusals of care. Although notes were brief we saw they were individual to each person.

The registered provider's PIR stated; 'We will be encouraging more staff to participate in activities. The intention is to continue to organise activities that involve the wider local community on an ongoing basis'.

We saw an activities coordinator held a quiz which was taking place on the morning of our inspection. We saw an activities planner which listed upcoming activities and events. People we spoke with said they didn't always have enough entertainment. One person said, "Not much entertainment here really." However, the same person spoke enthusiastically about a visitor to the home who had brought barn owls for people to see a few days before our inspection. We saw pictures of a visiting donkey which people also enjoyed.

The registered provider's December 2016 satisfaction survey completed by 12 people showed mixed levels of satisfaction with activities. We discussed activities with the manager who told us people had asked for more stimulation. In response, the registered provider had agreed 26 hours per week to cover an additional activities coordinator. The regional director said this would mean activities could be provided across seven days a week once this staff member was in post.

Care plans contained detailed records of people's participation in activities, which included information relating to their level of engagement and mood during the activity. This enabled the provider to measure the effectiveness of the activities and helped to identify any changes in the person's mood or demeanour.

We looked at how the service responded to complaints and found this was appropriately managed. Information on how to complain was seen on display. People told us they felt they could raise concerns with staff, although one person said they felt anxious about complaining in case of repercussions.

We looked at records of complaints received and saw these were all responded to. The manager kept records to track the progress of complaints and also analysed emerging trends and themes. The manager told us they had looked back at complaints management before they had taken post. They said, "An awful lot of complaints were dangling." We saw they had written to people who had not been contacted to ensure their complaints had been resolved.

The home had received a large number of compliments from relatives of people who used the service. Feedback included, 'Thank you for the support and smiles – you always made [name of person]'s day brighter,' 'Thank you all for the wonderful care [name of person] received. I know they really appreciated everyone's friendship' and 'It has been enormously reassuring to witness the care of staff who have been working to meet [name of person]'s needs. I know they appreciated their efforts'.

Requires Improvement

Is the service well-led?

Our findings

Most people we spoke with were aware there had been a change to the management of Sabourn Court Care Home in the summer of 2016. In the October 2016 resident and relative meeting, one person noted it would have been useful for a letter to have come out to formally announce the arrival of the new manager. The manager had acknowledged this and apologised for the omission.

People we spoke with said there had been a change in management styles. One person said, "We used to have a lovely lady that would come and talk to us. Now we have a man. I don't see him much." Another person said, "I don't see the manager." A third person said they thought the service was well managed, but noted there were lots of changes taking place. We saw a manager's lunch with people had taken place in Park House and another had been scheduled for people living in Oakwood House. In response to feedback from people after the first manager's lunch, we saw feedback on display stated the manager's lunch would take place once a month in each building.

Staff we spoke with told us they did not feel supported by the manager who they said did not have a visible presence in the home. Comments included; "This manager doesn't interact with anyone. It has changed the morale. There's no leadership", "I don't know the man. He never comes out of his office" and "Communication could improve." We were given an example of re-decorating which was taking place in the lounge which staff told us they were not aware of until the contractors arrived. We saw evidence of a staff meeting which took place in September 2016. The manager told us the next meeting was due in February 2017.

The manager told us they wanted nursing staff to have more accountability and staff to develop their own decision making skills. The regional director acknowledged there had been a significant difference in the management style of this service.

The manager was happy with the support they received from the senior management team. The regional director visited at least once a fortnight.

We saw there was a robust system of audit in place, and the manager had a running action plan which showed how they were driving the required improvements in the service. We saw records of a twice daily walk-round and 'Take 10' meeting, used to ensure information relating to the manager's observations, clinical risks, resident of the day, care plan reviews and other key information was shared between the manager and senior staff. We saw actions were delegated and followed up.

The manager and regional director were involved in a separate programme of audits. These included specific areas such as health and safety, care plans and infection control, and an on-going home improvement plan which showed what actions were needed, who would compete them and by when, and when these had been finished. The manager also had access to a range of reports from the registered provider which collated data relating to areas such as falls, nutritional risks, pressure ulcer development, safeguarding and complaints. We saw the manager reviewed these and added actions to the home

improvement plan as required. The manager told us they could get additional support from the provider's quality team where any areas of concern were identified.

Resident and relatives meetings took place every three months, although the July 2016 meeting had not taken place. We looked at the minutes from the October 2016 meeting and saw a variety of topics discussed such as staffing, laundry, maintenance, menus and activities. There was clear evidence of the 'service user voice'. We saw information on display which showed how the registered provider had responded to people's feedback about the service.

We looked at feedback from the registered provider's December 2016 satisfaction survey which showed levels of satisfaction recorded. People reported they were 'happy and content', 'listened to by staff' and 'treated as individuals'.