Care Quality Commission

Bupa Care Homes (BNH) Limited

Amberley Court Nursing Home

Inspection report

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Date of inspection visit: 9 and 10 October 2014
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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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

Amberley Court provides accommodation, nursing and personal care for up to 62 people with physical disabilities. Accommodation is arranged over two floors and there is a passenger lift to assist people to move between floors. There were 47 people living at the home at the time of our inspection.

The inspection was unannounced and was carried out over two days on 9 and 10 October 2014.

The registered manager left the service in August 2014 and a new manager had been appointed but was not yet registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We last inspected Amberley Court in August 2013. At that inspection we found the provider was meeting all the essential standards we assessed.

Summary of findings

Staff were not always following the Mental Capacity Act 2005. For example, the provider had not made an application under the Mental Capacity Act Deprivation of Liberty Safeguards for people even though their liberty may have been restricted.

Staff we spoke with understood that they had responsibility to take action to protect people from harm. However senior staff did not know how to contact external agencies to share their concerns and arrangements in place did not ensure that learning from events would take place to ensure risks to people were minimised.

People who needed support to eat and drink to prevent the risk of poor nutrition and dehydration had not always received this support effectively.

People told us that staff were caring and kind and they told us that they felt safe with staff.

During our inspection we saw many positive interactions between staff and people that lived at the home.

People told us that they received their medication on time and in a way that they wanted. Arrangements in place ensured that medication was stored safely.

Staff knew about people's needs. Staff told us that some training was needed, and we saw that training dates had been planned to ensure that staff received the appropriate training to enable them to deliver care safely and effectively.

People told us that staff listened to them and they knew how to raise concerns. The manager responded to people's complaints and took action to improve the service as a result of complaints.

We saw that people were supported to take part in individual hobbies and interests at the service and in the local community.

There were systems in place for monitoring the service. However, these had not always been timely and effective to identify where the improvements were needed.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to the following; The requirements of DoLS, and supporting people to eat and drink effectively. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? Some aspects of the service were not safe. Arrangements in place to minimise the risk of abuse had not always been effective. There were systems in place to make sure staffing levels were maintained at a safe level. Arrangements were in place so that medicines were managed safely.	**Requires Improvement**
Is the service effective? Some aspects of the service were not effective. There were arrangements in place to ensure that decisions were made in people's best interest. However, the deprivation of liberty safeguards had not been followed. This did not ensure people's rights had been protected. People did not always receive the support they needed to eat and drink effectively, and reduce the risks of poor hydration.	**Requires Improvement**
Is the service caring? The service was caring People told us that staff were kind and caring. Staff knew people's needs and how they wanted their care provided. People told us that staff respected their privacy and dignity and we observed this.	**Good**
Is the service responsive? The service was responsive. People told us that they knew how to raise a concern or complaint and that they felt they would be listened to. Opportunities were provided for people to take part in a range of hobbies and interest in the home and in the local community.	**Good**
Is the service well-led? Some aspects of the service was not well- led. Monitoring of the service had not always been effective and timely in identifying where improvements were needed. People told us that the new manager was approachable and welcoming. Staff told us they felt they could discuss their practice with their manager and understood their responsibility to report concerns.	**Requires Improvement**

Care Quality Commission

Amberley Court 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.

The inspection took place on 9 and 10 October 2014. The first day of our inspection was unannounced. The inspection team included two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. On the first day of our inspection we focused on speaking with people who lived in the home, staff and observing how people were cared for. One inspector returned to the home the next day to look in more detail at some areas and to look at records related to the running of the service.

During our inspection we spoke with 15 people who lived at the home, ten staff, the manager and the provider representative. After our inspection we spoke with two healthcare professionals.

We observed how people were supported during their lunch and during individual tasks and activities. We looked at six people's care records to see if their records were accurate and up to date. We looked at medicine management processes and records maintained by the home about staffing, training and monitoring the quality of the service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We received the PIR within the required timescale and used the information from this to help inform our inspection process.

We checked the information we held about the service and the provider. This included notification's received from the provider about deaths, accidents and safeguarding alerts. A notification is information about important events which the provider is required to send us by law.

We requested information about the service from Birmingham Local Authority and Birmingham NHS Commissioning Group. Both have responsibility for funding people who used the service and monitoring its quality.

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Is the service safe?

Our findings

All the people we spoke with said they felt safe and did not have any concerns about abuse or bullying from staff. One person describe that a staff member had been disrespectful in their approach towards them. They told us that this had been reported and dealt with by the manager and they were satisfied with how it had been managed.

We spoke with five members of staff who were able to tell us about different types of abuse and how they would respond to allegations or incidents of abuse. Staff we spoke with knew the lines of reporting within the organisation and told us that they were confident that if they reported concerns to the deputy or manager they would be acted upon. However, staff in a senior position that we spoke with did not know how to make a safeguarding alert to the local authority in line with local protocols and information about local protocols were not available for staff to refer to. Local protocols would ensure that different agencies work together to minimise risks to people. This could lead to a delay in reporting incidents and people being at risk of further abuse if the manager was absent from the service. However, since the manager had been in post we had received formal notifications about concerns they needed to report.

The local authority had notified us about a safeguarding incident that had recently happened in the home. It was about a person who was unwell and a visiting healthcare professional had raised concern about poor care, failure to keep a person safe and concern about the conduct of a senior staff member responsible for dealing with an emergency situation. The incident had been investigated by a health care professional and had been discussed with a senior staff member in the home. The manager told us that they did not know about this incident as it had happened shortly before they started working in the home and information had not been shared with the provider's representative. Therefore action had not been taken to minimise the risk of reoccurrence and no action had been taken in respect of the staff member concerned.

A healthcare professional told us that following a visit to the home in October 2014 they raised concern about poor health care outcomes for two people. This information was shared with the local authority under safeguarding local procedures.

People who could tell us told us that they felt safe when supported by staff and that they had the equipment they needed to keep them safe. This included specialist lifting equipment and specialist wheelchairs. We observed that people were supported to transfer from a wheelchair to a chair safely. We saw that equipment was used to prevent risks to people. This included specialist beds and mattresses so that the risks of sore skin were minimised. People's care records included risk assessments for mobility, falls and pressure care. We saw that one of the six care records we looked at were incomplete and not all risk assessments had been completed. This could lead to inconsistencies with how staff managed risks to people. However, staff that we spoke with knew what people's needs were and how to manage the risks.

One person who lived on the ground floor of the home told us, "The staff are really good but there is just not enough staff. In the afternoon there is only one care staff on this side of the home. I need two people to assist me. The staff ring around the home to try and get another staff member from one of the other units to assist". Another person who was living on the first floor told us that the staff were very good but were always very busy and sometimes they needed to wait a while for staff assistance.

We observed that staff made checks on people who were cared for in bed to ensure they were safe and we saw that staff responded promptly to call bells. There was also an emergency situation during the inspection and we saw that staff responded promptly to this.

We spoke with five staff members and received variable feedback from them about staffing levels. One staff member told us that staffing was not adequate and they felt rushed in their role and the other staff felt told us that staffing levels were adequate. The service was soon to start admissions for 'winter pressure beds'. This is when and the manager told us that the increase in people living there would be planned in a way to ensure that staffing resources were available to meet people's needs safely.

The manager told us that all care staff posts had been appointed to. However, there were four vacant posts for qualified nurses and we were made aware during the inspection that an additional two more nurses would be leaving for personal development positions. The manager told us that the provider was looking at ways to promote

Is the service safe?

positive recruitment to vacant posts for qualified nurses. Vacant hours were covered by staff taking on extra hours and in some instances agency staff were used so that safe staffing levels were maintained.

The manager told us that they had a system for ensuring safe staffing levels were maintained. He told us that some recent improvements to the system had taken place. This included assessing people's dependency level and improving how assessments were completed of people's needs prior to their admission to the home. We saw that staffing levels were discussed in senior staff meeting. This provided senior staff with the opportunity to share any concerns. The manager told us that new admissions to the home planned to take place at the end of October would be phased, so that safe staffing levels would be maintained and that some additional work around assessing staffing levels would be completed by the end of October 2014.

People were supported so that they received their medication safely. We spoke with four people about the support that they received from staff to take their medication safely and in a way that they prefer. They all told us that they received their medication on time, and that they knew the medication they were taking and what it was for. One person told us that they wanted to manage their own medicines and that staff had supported them to do this.

We spoke with two staff members who told us the steps they had taken to ensure people were supported to take their medicines safely. We saw that medicines were stored safely and records were kept of medicines received. We looked at four people's Medication Administration Records (MAR) and we saw that these had been completed to confirm that people had received their medicines as prescribed. We spoke with two nurses who were able to tell us about the medicines four people were taking, and the reasons that people had been prescribed the medicines.

Is the service effective?

Our findings

We looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of people using services by ensuring that if there are restrictions on their freedom and liberty that these are assessed by professionals who are trained to assess whether the restriction is needed.

We saw that some people who may lack capacity were closely supervised and some people had restrictions in place. However, no application to authorise these restraints on people had been made. This meant that the provider had not followed the requirements of the DoLS. The manager told us that he understood his responsibility to apply DoLS effectively. In the few weeks that he had been working in the home he recognised that applications needed to be made to the local authority and he told us that he would be starting the referral process. We spoke with senior and clinical staff about their understanding of DoLS, only one staff member could clearly describe the implications of DoLS. Staff had not received training in DoLS and Mental Capacity Act. Which may account for why the safeguards had not been applied. The manager told us that this training had been planned to take place very soon so that staff had the required knowledge and understanding of their responsibility. Arrangements in place did not ensure that the provider had taken steps to ensure the legislation was appropriately applied and people's rights upheld. This was a breach in regulation 11 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider had failed to ensure that an effective system was in place to ensure they were applying DoLS appropriately.

We discussed the Mental Capacity Act 2005 with the manager. They showed that they were knowledgeable about how to ensure that the rights of people who were not able to make or communicate their own decisions were protected. We saw care records showed that the MCA code of practice principles had been used when decisions were made in people's best interest. For example we saw that one person had been assessed as unable to make important decisions about their care and their care plan specified the steps that must be taken so that decisions were made in their best interest. The manager recognised that important decisions needed the involvement of other health and social care professionals and they told us about the steps that they had taken to arrange a 'Best Interest' meeting.

With the exception of one person, all of the people we spoke with were positive about the food served. One person told us, "The food is very good. There are always two choices at every meal. If you do not like what is on the menu they will make you what you want. When it's your birthday the chef always makes you a wonderful birthday cake". Another person told us, "Sometimes I do not fancy what is on the menu. I just tell the staff and the chef will make me something that I like".

We saw that people were not always supported effectively to meet their eating and drinking needs. We observed the lunchtime meal in the main dining room. We saw that not all people received the support they needed, in a way that met their needs. A staff member was standing to assist a person who needed support, to eat safely. A senior staff member needed to tell the staff member to sit down, so that they were in the appropriate position to support the person to eat safely and in accordance with the person's care plan so their health needs were met.

We saw that all the dining tables in use where raised tables that were designed for people who used a wheelchair. We saw two people who did not use a wheelchair using the tables. They needed to reach upwards to eat their food and we saw that they had some difficulty reaching the height of the table. We spoke to the manager about this and they told us that they had identified that the dining facilities were a concern for some people and would be addressing this. We observed a person who had some difficulty eating their food. We asked two staff members about the person's needs, and they told us that assessments of their eating needs had not been completed. They had not considered that this may be needed for this individual. An assessment of people's eating needs would help to identify any supportive equipment needed to support people to eat safely and independently. However, we did see that assessments for some people had taken place and they had been provided with the equipment they needed.

A number of people who lived at the home received their food and drink through a PEG. This is when a tube is passed into a persons' stomach to provide a means of feeding. Staff told us that people had a prescribed amount of daily fluid that was needed to keep people hydrated and that

Is the service effective?

they were expected to record and total the amount daily to ensure that people were properly hydrated. However, we saw that the care records for three people had not been maintained as needed. Also two people's prescribed nutrition amount recorded on their care records was different to the amount prescribed by the dietician. People had not been protected from the risk of inadequate nutrition and hydration.

Arrangements in place did not ensure that people had received the support they needed to eat and drink effectively. This was a breach in regulation 14 (1) (c) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke with two visiting health care professionals after our inspection who told us that they had recently raised concerns about two people's PEG site not being properly cared for by nursing staff. People who have a PEG for feed, medicines or fluid need nursing staff to carry out regular tasks to prevent the PEG site becoming blocked and to ensure the site remains healthy and to prevent the tube from becoming embedded in the stomach and these tasks had not been completed as needed to prevent this happening. This showed that staff lacked some clinical skills and knowledge to support people who had a PEG effectively.

Three staff told us that there were plans in place so that they completed training specific to their nursing role so they had the skills they needed to carry out their clinical duties effectively. One nurse told us "[manager's name] has been really supportive since he took up post and has been arranging clinical training for us so we have the skills and knowledge we need". Two care staff told us that they needed training updates. The manager told us that he had identified that training in a number of areas was needed and showed us the training tracker that they used to identify training needs. We saw records confirming that training sessions had been scheduled. Following our inspection the manager told us that in addition to the planned training that training for nursing staff on managing PEG's had also been identified following concerns expressed from health care professionals.

All the staff told us that there was a supervision and appraisal structure in place however; this had been infrequent in recent months. All staff told us that they could speak to senior staff or the manager if they needed to. The manager told us that a new management structure was now in place and that regular and effective staff supervision would take place so that staff received the support they needed to carry out their role.

One person told us, "If I am not well then I just let the staff know and they will contact the doctor for me." Another person told us that staff had made a referral so they could be assessed for a specialist wheelchair. Records we looked at confirmed that referrals had been made to health care professionals including dietician services, physiotherapy, and speech and language services. We also spoke with a health care professional who told us that they carried out visits to the home to assess the on-going needs of people who were funded through continuing health care. This showed that other health care professionals were involved in people's care and people had access to on-going healthcare support.

A number of people we spoke with told us that there had been recent changes to the arrangements for them to see a GP and that they were concerned about this. The manager told us about the steps they had taken to respond to people's concerns and that he had appropriately contacted external agencies responsible for the decision and that a meeting had been arranged.

Good

Is the service caring?

Our findings

All the interactions we observed between staff and people were positive and indicated that staff had developed good relationships with people. We saw that staff were kind and compassionate in their approach with people.

People told us that staff were caring and that they liked the staff. "One person told us, "I really like the staff they are caring and kind". Two people told us about their experiences and they told us how their health and wellbeing had really improved whilst staying at Amberley Court. They attributed this to the care and attention of the staff that had supported them.

All the people we spoke with told us that they felt staff listened to them. We saw staff sitting and talking with people. One person told us how staff had supported them to keep their own pet at the home. The person told us that this had meant so much to them personally and they felt that the staff had recognised the importance of this and had listened to what they really wanted.

People told us that they were involved in making decisions and planning their own care. One person said, "Staff ask me about my care and will ask me how I want things done." One person who recently moved into the home said, "I love it here because I am looked after, yet I have freedom to live life and be treated like an adult".

People told us that they felt staff knew their needs well. Records that we looked at had information about people's likes and interests. This provided staff with information they needed so they had an understanding of people's needs, preferences which helped provide personalised care.

We found that people's privacy and dignity was promoted. All the staff we spoke with were able to give us a good account of how they promoted privacy and dignity in everyday practice and demonstrated an understanding of how important it was to do this, when carrying out their role. We saw that staff entered people's rooms and checked on people to make sure they were comfortable and not in any discomfort or distress. We observed that staff ensured they closed people's bedroom door before they attended to people's care. We also saw that staff knocked on people's bedroom doors, and where possible waited for the person to respond, before attending to their care.

Staff demonstrated that they understood and empathised with people who had suffered loss and bereavement. There had been some recent bereavement at the home. We saw that staff and people living there really supported each other at this difficult time with mutual compassion and respect. People were supported to attend a funeral service and express their condolence. One person said, "The staff have been very understanding and supportive to us during this very difficult time, we have lost a friend".

Good

Is the service responsive?

Our findings

All the people we spoke with told us that staff knew their needs and the things that were important to them. They told us that staff consulted with them about their care. One person said, "I have told staff that I do not want to be checked by them during the night. This was listened to and is in my care records." Another person said, Staff talk to me about my care plan I could see if it I wanted too, but I don't bother because they ask me about how I want things to be done". This showed that staff listened to and respected people's views.

People received support to take part in hobbies, interests and social activities. One person told us that staff had supported them to find out about the opportunity of attending a day centre in the local community and they were very keen to do this. We saw that some people accessed facilities in the community independently. One person said, "There are lots of activities that we can take part in if we want to. I like to spend time in my own room. I have all my own things around me that I like. I listen to music. I have my own pictures and drawings. I am planning a trip out to a local shopping centre and staff will come with me to support me".

We saw that the home had a range of leisure and social facilities. This included a games room, physiotherapy room and a computer suite. We saw that the design of these ensured that the facilities were accessible to people with physical disabilities. For example, the computer suite was designed so that people who used a wheelchair could access the computer equipment. In the games room the dart board was at a level that was appropriate height for people who used a wheelchair. The garden are was designed so that people who used a wheelchair could access outside areas independently. The manager told us that they had consulted with people about introducing new recreational activities based on people's interest and aspirations. For example the manager was exploring the introduction of astronomy sessions following feedback from people. This showed that the manager was responding to the specific needs and interest of people.

People told us that they were supported to maintain relationships that are important to them. One person said "My family and friends can come any time they want to". All the people we spoke with told us that friends and families could visit anytime and we saw some visitors at the time of the inspection. One person told us that social events were arranged and people invited their family and friends. In the summer a garden party had taken place and people told us that it had been well attended by family and friends.

One person said, "I do go to the residents meetings we talk about different things going on at the home". Another person told us about the work that was taking place to change the use of a room at the home, into a cinema facility and this is what people wanted and it had been agreed in a recent residents meeting. This showed that people had been consulted with about changes and developments of the service.

All of the people we spoke with told us that if they were not happy about something they would speak to one of the staff or the manager. One person told us, "I can speak to [staff members name] or the manager. They will sit and listen to you and they are willing to discuss things. Another person told us, "I would tell any of the staff if I was unhappy about something, I cannot fault the staff". One person told us about an incident when two staff members who had their own personal conversation whilst supporting them with their personal care and this had been inappropriate. However, the manager had been told about the incident and had dealt with this matter. Information about how to complain was displayed in the entrance hall. We saw that records were made of any complaints made and the outcome of any investigation was recorded.

Is the service well-led?

Our findings

The provider told us about the management changes for this service. The registered manager moved to one of the providers other registered services and a new manager was appointed in September 2014. When we inspected they had only worked at the home for four weeks but were already in the process of applying to the Care Quality Commission to be the registered manager.

There had also been changes at deputy manager level and we were told by the manager that an experienced nurse had been promoted to the deputy/ clinical lead role. All the people and staff that we spoke with were aware of the management changes in the home and they knew the line of accountability in the service.

We found breaches of regulation in relation to DoLS and meeting nutritional needs. The provider should have taken action to ensure that these regulations were being met. The manager told us at the start of the inspection that they had already identified specific areas that needed improvement. This included improving arrangements for mealtimes, looking at staff deployment throughout the home and consulting with people about their hobbies and interest.

We saw records of audits that had been carried out to assess the quality of the service. However these systems had not always been timely and effective in identifying some of the risks relating to the health, welfare and safety of people. The manager was unable to tell us what learning had taken place from a recent safeguarding incident because the information had not been shared and used effectively to minimise the risk of reoccurrence.

We saw that the manager was visible during the inspection and spent time talking to people and visitors. People told us the manager was approachable. One person said, “He [the manager] is not stuck in the office you see him walking around and talking to people”. Most people we spoke with were complimentary about the new manager. Staff and people that we spoke with told us that he was approachable and would walk around the home to speak with people, and to see what was happening in the home.

We were told by the manager that no recent feedback surveys had taken place with the people who lived there or their relatives to ask people their views about the service provision. However, the manager told us that they planned to do this. We saw that a meeting schedule had been implemented and a range of meetings had started to take place across the service. This included meetings with staff responsible for care, domestic, catering and health and safety. The manager told us that these will be a forum for ensuring that staff in all roles had a shared understanding of risks and challenges within the service.

All the staff we spoke with understood their right to share any concerns about the care at the home. All the staff we spoke with were aware of the provider’s whistle blowing policy. Staff told us that they would raise concerns if they needed to and that they felt they would be listened to.

We had been informed of reportable incidents as required by CQC and the manager demonstrated they were aware of when we should be made aware of events that had taken place in the home. However, poor communication in relation to a safeguarding incident meant that lessons had not been learnt and prevented steps taken to minimise the risk of reoccurrence.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The provider had failed to ensure that an effective system was in place to prevent people been unnecessarily deprived of their liberty.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The provider had not taken proper steps to ensure that people were protected from the risk of poor nutrition and hydration.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.