Bupa Care Homes (ANS) Limited

Pebble Mill Care Home

Inspection report

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09 May 2019

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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 responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service:
Pebble Mill is a care home that provides nursing and personal care for older people, most of whom are living with dementia. At the time of the inspection, 36 people lived at the service. The accommodation is organised into three floors, each with its own communal areas.

People's experience of using this service:
People did not always receive safe and effective care that was personalised to their needs. Some people had not received their medication as it was not in stock and staff did not always follow care plans to ensure people's safety when helping people to move. Staff did not respond in a timely way when people used their call bells to request assistance.

Senior staff did not keep an oversight of day to day practice which meant that issues that were identified at this inspection had not been addressed. The service did not notify us of Deprivation of Liberty Safeguards applications that had been granted as required.

There were enough staff on duty to keep people safe and the provider carried out checks on new staff to make sure they were suitable to work in the home.

The home was spacious, well-decorated and clean and people had the opportunity to spend time alone or with visitors in privacy. People were generally happy with the food and individual preferences were catered for. People did not always have the opportunity to have a drink when they wanted one.

Staff showed compassion and were patient with people when they were upset or distressed but did not always take the opportunity to spend time talking and interacting with people. People did not always have the opportunity to express how they wanted their care delivered which meant they did not always receive care that was personalised.

The provider responded promptly to any concerns and complaints that were received and worked well with other agencies to promote people's health and ensured people were well supported at the end of their life.

Some audits and checks were effective in highlighting gaps in record keeping and practice and where gaps had been identified, action had been taken to improve the quality of care and support. The provider and registered manager were open and honest throughout the inspection and were committed to address the issues highlighted at this inspection.

More information is in the detailed findings below.

Rating at last inspection:
This was our first inspection of this service since their registration in March 2018.

Why we inspected:
This was a planned inspection.

Enforcement:
Please see the 'action we have told the provider to take' section towards the end of the report.

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Details are in our Well-Led findings below.

Pebble Mill Care Home

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team:
The inspection team consisted of one inspector, one assistant inspector, one specialist advisor (who was a qualified nurse) and one Expert by Experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of service.

Service and service type:
Pebble Mill is a care home. People in care homes receive accommodation and personal care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection on 08 May 2019 was unannounced and one inspector returned on 09 May 2019 which was announced.

What we did:
We reviewed information we had received about the service since it opened. This included details about incidents the provider must notify us about, such as abuse; and we sought feedback from the local authority and other professionals who work with the service. We assessed the Provider Information Return (PIR) that had been submitted. Providers are required to send us a PIR at least once annually to give some key information about their service, what they do well and improvements they plan to make. This information helps support our inspections.

During the inspection we spoke with eleven people and four relatives to ask about their experience of the care provided. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We also spoke with one senior carer, four members of care staff, two nurses, the assistant chef, the registered manager, the deputy manager, one activities co-ordinator and the provider.

We reviewed a range of records. This included six people's care records and medicine records. We looked at two staff files around staff recruitment. We also reviewed records relating to the management of the home including checks and audits.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● Some people had not received their medication when required. For example, records showed us one person had not received one of their prescribed medications for the four days leading up to the inspection. One relative told us, "The family have to bring in the medication because they [the provider] did not have it available." We spoke to the registered manager about this who explained the pharmacy had run out of stock and had not been able to supply some medicines for people. Although efforts had been made to chase this up, staff had not checked with GPs promptly to assess the level of risk to people who had not received their medication. Staff had also not followed the provider's policy of trying to obtain medicines from other pharmacies.

● Staff were unclear as how to give some medicines; for example, one nurse was unclear whether one person should be given insulin before or after food and there were no clear instructions on the care records.

● Where medication was supplied, records showed that people received their medication as prescribed. Medications were stored safely and staff told people what they were taking when giving medication.

● We saw that some people's prescribed creams did not have an 'opened date' which meant staff could not check the creams were still safe to use.

● Some medicines were being given covertly as it had been assessed as this was in the person's best interests. We found that agreement to give medication in this way had not always been requested from medical professionals to ensure medicines were safe to be given with food.

The failure to ensure people received their prescribed medication was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

Assessing risk, safety monitoring and management

● Staff did not always deliver support safely and in line with people's care plans. For example, we saw one person being fed in bed. This person had been assessed to be at risk of choking but had not been encouraged to sit up in bed to reduce this risk.

● Staff did not follow safe processes when supporting people to move. For example, foot plates on wheelchairs were not always moved out of the way and we observed one person being moved from a chair to a wheelchair without the use of a walking frame as stated in their care plan. We saw that people did not always have easy access equipment such as walking aids and slide sheets to help them keep safe.

● Records showed that checks were carried out on the building to ensure people were kept safe. These included checks on fire safety and moving and handling equipment and we saw the environment was free from clutter to reduce the risk of trips and falls.

The failure to deliver safe care and support was a breach of Regulation 12 of the Health and Social Care Act

2008 (regulated activities) Regulation 2014

Staffing and recruitment

● Relatives and their relatives had concerns about staffing levels. People's comments included, "The service is sluggish and I have a long wait for someone to come to my room," and, "Yes, I have to wait as I don't think they have enough staff." Staff also told us that sometimes they were left short of staff if colleagues were on holiday or escorting people to appointments.

● We observed staffing levels on the two floors during the inspection and staff did not seem rushed and had time to spend with people. However, we looked at call bell audits which showed that staff did not respond to call bells in a timely manner. For example, seven calls had not been responded to within 20 minutes on 08 May 2019.

● We spoke to the manager about staffing levels and saw that they were using a dependency tool which was reviewed weekly. This indicated there were sufficient staff to meet people's needs. We looked at rotas for the four weeks leading up to the inspection and there had only been three shifts that had not been fully staffed.

● Staff had been recruited safely to ensure they were suitable to work with vulnerable people.

Systems and processes to safeguard people from risk of abuse

● People told us that staff kept them safe in the home. One person told us, "Safe? Absolutely, I have a music teacher and the first time they came they wouldn't let him in. I think they are very good with security". People also told us that staff checked on them regularly through the night which they liked.

● The provider had effective safeguarding systems in place. Staff had received training in how to recognise abuse to protect people from harm and knew they could contact a helpline run by the provider or CQC if they had concerns. Staff were confident that action would be taken if they raised concerns. One member of staff said, "They covered safeguarding in my induction and I would report anything to the manager."

Learning lessons when things go wrong

● Incidents and accidents were investigated and an analysis was undertaken to reduce the risk of re-occurrence. For example, a review of falls had indicated an increased risk to people during late evening times. The provider had therefore increased staffing levels during this period and how often people were checked. Falls had reduced in recent months.

Preventing and controlling infection

● The home was clean and staff used personal protective equipment to reduce the risk of infection.

● We saw that the home had been awarded a five star food hygiene rating by Birmingham City Council in April 2019.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Supporting people to eat and drink enough to maintain a balanced diet

- People told us that they did not always get a drink when the needed or liked one. We observed one person asking for a cup of tea but was told that the drinks trolley wasn't coming round for another 35 minutes.
- People and relatives were generally happy with the food provided. One person said, "The food is jolly good here. I have met the cook and told her".
- We observed lunch in all of the units and we saw that people could choose to eat in the dining rooms, lounges or their rooms. We saw that people were able to make choices. For example, two people had individual meals prepared for them at short notice. There were enough staff supporting people to eat at lunchtime so that everyone had the help they needed.
- Records showed that people's food and fluid intake was recorded and monitored if people were at risk from weight loss. These records showed that people were maintaining healthy weights..

Staff support; induction skills, knowledge and experience

- Staff told us and records showed that a significant number of staff were not receiving regular supervision or an annual appraisal. This meant that staff did not regularly have the opportunity to reflect on their practice or development. We asked the provider about this who recognised that there was work to be done to ensure all supervisions and appraisals were completed.
- People were supported by staff who had received appropriate training to enable them to deliver effective care. There was a system in place to monitor and ensure that staff training was up to date, and refresher training was completed.
- New staff completed an induction and mandatory training when they first started work in the home. One member of staff told us, "I did two weeks shadowing when I first started which was great." The provider told us that the induction programme included the Care Certificate which is
is an identified set of induction standards to equip staff with the knowledge they need to provide safe and effective care.

Ensuring consent to care and treatment in line with law and guidance

- 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
● Mental Capacity assessments had been completed appropriately and DoLS applications had been made when people did not have the capacity to consent to receiving care and treatment.
Where DoLS had been granted, records showed that people were visited by their Relevant Person's Representative (RPR). A RPR is appointed to support a person who is deprived of their liberty under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DOLS).
● Some people told us they felt they were treated as though they lacked capacity and had some choices made for them especially when they first arrived at the home. For example, one person told us, "I'm treated as though I had no intelligence but that was to be expected as they don't know your needs at first."
● Staff had received training in MCA and DoLS. One member of staff told us, "Not everyone can make a choice but we have to make a judgment in their best interests sometimes."
● Where people did not have capacity to make decisions, they were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Records showed that best interests decisions had been made for people where appropriate and that relevant advocates and professionals had been consulted.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People had access to visits from external healthcare professionals such as GPs, dieticians and occupational therapists. Records showed that people were referred to specialist teams when required. The GP who was visiting at the time of the inspection told us they were happy with the referrals made by the staff team and thought staff followed up on their instructions.
● Staff were vigilant in monitoring people's health, such as checking people's bowel movements and skin when required.

Adapting service, design, decoration to meet people's needs
● Communal areas were spacious and well laid out and people could choose to spend time in their rooms or in communal areas. There were separate lounges and dining areas which enabled people to have some privacy when family and friends visited.
● There was a large enclosed garden which relatives told us people enjoyed in warmer weather as well as a hair salon and cinema room. The building was decorated to a high standard and all rooms had ensuite bathrooms and air conditioning to make people feel comfortable. The lounge areas had settees, so people could sit next to each other.
● People's bedroom doors had personalised pictures to help them find their rooms and walls were decorated in neutral colours to create a calm environment.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed prior to admission and were reviewed every month. One relative said, "My Mum was visited in hospital for an assessment prior to admission and we had a chance to look around."
● Records showed that the management team made referrals to healthcare professionals appropriately in order to deliver care in line with best practice guidelines.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care

- People told us they were not always asked to make choices or staff did not always respect their wishes. One person told us they had declined care in the past but it had still been delivered. We also observed one member of staff telling someone they needed a shave before walking away and the person did not get chance to express their wishes.
- People did have the opportunity to make some choices such as at meal times and whether they wanted to join in with the activities that were on offer.

Ensuring people are well treated and supported; respecting equality and diversity

- There were periods during the day when staff could have made more use of the opportunity to chat with people. We observed many interactions between staff and people which were task focussed rather than a conversation or an activity. One person said, "They [the staff] spend more time writing in the folder than talking to me." We spoke to the registered manager and provider about this who agreed staff development was required in this area.
- People and their relatives were mostly positive about the staff's caring attitude. People's feedback included, "The staff treat me with respect," and, "The staff look after me here". We observed staff supporting people with calmness and patience when people were upset or distressed.
- Staff were aware of the individual wishes of people living at the home that related to their culture and faith. Care files contained information about people's personal histories, people's preferences and interests so staff could consider people's individual needs when delivering their care. This helped staff to respect people's individuality and diversity and understood how people's past experiences could affect their responses now. For example, we saw people's preferences for female staff being respected and people being provided with specific food in line with their culture.

Respecting and promoting people's privacy, dignity and independence

- People's independence was not consistently respected and promoted. For example, walking frames were not always available to help people move independently and some people wanted to make their own drinks but had been told they were not allowed. However, we did see staff cutting up one person's food so that they could feed themselves and we also observed a member of staff encouraging one person to walk to the toilet on their own as they did not need staff support.
- People's dignity and privacy was not always respected. For example, we saw that catheter bags were not emptied regularly or placed out of view in people's bedrooms.
- People were supported to maintain and develop relationships with those close to them. There were a number of visitors during the inspection and relatives told us they were made to feel welcome at any time.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them control

- Peoples' needs had been assessed but care and support was not always provided in line with these assessments and peoples' preferences. For example, a number of people told us they would they would like to have their care and support delivered differently such as being given drinks through the night when they wanted one.
- Records showed that one person was not re-positioned in their bed on a regular basis in line with their care plan and during the inspection, two people did not have access to their call bells which meant they could not call for assistance.
- There were activities organised on the day of inspection that some people enjoyed and we saw that people had a choice of whether to join in. People had mixed views on whether the activities were organised in line with their interests, but we did see evidence of a range of activities that people had enjoyed in recent months. One relative said "My [family member's name] is very happy here and is starting to make friends. They do try and provide some stimulation for everyone and they have really enjoyed the music and the animal visits".
- The service did not always present information in a way that was accessible to the people living in the home. For example, the menus in the dining rooms were in written format when pictures or showing people living with dementia two plates of food would have been more appropriate to help some people make choices about meals.

End of life care and support

- Some people were receiving end of life care at the time of our inspection. These people were receiving good care and support and the provider was working well with other professionals to ensure people were as comfortable as possible. For example, we saw that clinical nurses from a local hospice had visited to assist with one person's medication.
- Care plans recorded people's wishes as to how they wanted to be supported in the future at the end of their life.

Improving care quality in response to complaints or concerns

- People and relatives, we spoke with knew how to complain and felt confident that any concerns would be dealt with quickly. One relative told us "I have had a few small concerns but staff do listen and respond."
- The provider had received seven complaints in the last 12 months; a number of these were around being visitors being able to access the building during evenings and weekends. We spoke to the registered manager about this who confirmed a new door access system was currently being installed to resolve this issue.
- The provider had received a range of compliments from people and their families thanking them for the support and care that had been provided.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- A range of checks and audits were carried out to monitor the performance of the service and staff. These included checks on falls, medication, health and safety and care plans. The registered manager and deputy manager also carried out spot checks overnight.
- These checks had not identified some of the issues we identified at this inspection and there was a lack of oversight and spot checks of the delivery of care and support on a day to day basis. For example, senior staff had not picked up on unsafe moving and handling techniques that we observed and action had not been taken to try and source medication for people that was out of stock at the normal pharmacy.
- Staff were not deployed efficiently to enable a high-quality service to be delivered. For example, we saw senior staff asking care staff to carry out tasks such as photocopying which took them away from delivering care and support.

The failure to monitor the quality and safety of whether staff were providing safe care that was in line with people's care needs was a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

- The provider had not notified us of DoLS that had been granted. Records showed that four DoLS had been granted but we had not received notifications for these.

The failure to notify us of DoLS that had been granted was a breach of Regulation 18 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and their relatives had mixed views on how well the service engaged with them. Records showed that meetings were held with people and relatives every three months and actions were taken as a result of these meetings. For example, a piano had been installed for people to use and there had been improvements to car par parking. However, there was limited opportunities for individuals to give feedback on how their care and support was being delivered.
- The registered manager and deputy were manager were visible throughout the day and took time to speak to people, their relatives and the staff team.
- Staff were generally positive about how the registered manager was leading the service but told us they

would like more support on a day to day basis, especially when dealing with people's behaviour when it became unpredictable. One member of staff told us, "The last one [incident] we had we just had to cope with the situation. We told them [management] but it just went over their heads". Other staff told us that they felt teams could work more closely for the benefit of the people living in the home.

Continuous learning and improving care

● There were clear plans in place to address areas for improvement that had been identified by audits and checks. Plans included records of action taken and progress made.

● We saw that the provider took an active interest in the running of the home and completed visits and checks to monitor how well the home was being run. The registered manager told us they felt well supported by the provider and we saw evidence that the provider was willing to allocate time and resources to help the home to improve.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on duty of candour responsibility

● The registered manager and the provider were open and transparent during the inspection and demonstrated a willingness to listen and improve.

● Relatives and professionals were informed of any incidents and told us they felt the home was well-run.

Working in partnership with others

● The service had good links with the local community and the provider worked in partnership for people's benefit. For example, some staff training had been delivered by community dieticians to improve staff's awareness in this area.

● The registered manager told us that people were receiving a good level of service from local GP surgeries.

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The provider had failed to notify us of Deprivation of Liberty Safeguards that had been granted as they are required to do so.

The enforcement action we took:

We have issued a fixed penalty notice.