Bupa Care Homes (BNH) Limited

The Arkley Nursing Home

Inspection report

140 Barnet Road
Barnet
Hertfordshire
EN5 3LJ

Tel: 02084495454

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 17 February 2016 and was unannounced. When we last inspected on 27 May 2015 we found the service was not meeting one of the regulations relating to providing personalised care to people. At the current visit we found that this breach had been addressed.

The Arkley Nursing Home is a nursing home that is registered to provide accommodation, nursing and personal care for up to sixty people. The home did not have a registered manager, but the manager had applied to register. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

A significant increase had been made to the number of permanent staff working in the home, so that no agency staff had been used within the last two months. People living at the home and their relatives indicated that this had resulted in a marked improvement in the quality of care they received. They described staff as caring and skilled, and said that the atmosphere of the home had improved. We also found improvements made to the management of medicines as recommended at our previous inspection.

A new management team was in place for the service, and people spoke positively about their impact and approachability. The provider had systems for monitoring the quality of the service and had engaged with people and their relatives for feedback, with action plans put in place to address issues of concern. When people made complaints they were addressed appropriately.

We found some gaps in staff supervision frequency particularly for care staff, and some areas for further training. Staff were not always aware of which people living at the home were subject to a deprivation of liberty safeguard, which might place people at risk of inappropriate care.

Staff had knowledge of people's preferences regarding their care and support needs. Personalised care plans were in place to record people's care needs, with risk assessments where needed to minimise the risk of harm. Staff were clear about the procedures for reporting abuse. Safe systems were in place for recruiting staff, and the home was kept clean and hygienic.

People were provided with a choice of food, and were supported to eat when this was needed. People had a range of activities available to them, and access to health and social care professionals when needed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Following a significant recruitment of new permanent staff, the home no longer relied on agency staff, increasing the continuity of care and reducing the risk to people.

Assessments were in place to minimise risks to people, and there were improvements in the management of medicines in the home including support to enable people to self medicate when appropriate.

Staff knew the correct procedures to follow if they suspected that abuse had occurred, and safe recruitment procedures were in place.

The home was clean and hygienic.

Is the service effective?

Requires Improvement

The service was not always effective. Staff supervision frequency did not ensure that they had the support and monitoring needed to care for people effectively.

Staff understood people's right to make choices about their care. However they were not aware of people who were subject to a Deprivation of Liberty Safeguard in order to ensure that their rights were protected accordingly.

People received a choice of meals and staff supported them to meet their nutritional needs.

People's health care needs were monitored. People were referred to the GP and other health care professionals as required.

Is the service caring?

Good

The service was caring. Staff were caring and knowledgeable about the people they supported.

There was consultation in place for people and their representatives about their care and support, and efforts were

made to meet their social and spiritual needs.

Is the service responsive?

Good

The service was responsive. People using the service and their relatives were encouraged to give feedback on the service and use the complaints system.

Person centred care plans were in place outlining people's care and support needs.

Staff were aware of people's support needs, their interests and preferences and attempted to provide a personalised service. A range of activities were available for people including occasional trips out of the home.

Is the service well-led?

Good

The service was well-led. The home had systems for assessing and monitoring the quality of the service, and had action plans in place to bring about improvements.

People described the management team as visible and approachable. We found that they were aware of the strengths and challenges of the home, and had an improvement plan in place to address areas for improvement.

The Arkley 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.

At the previous inspection of the home on 27 May 2015 we found that the provider was not meeting a legal requirement with regard to designing care to meet people's preferences and needs. We also made four recommendations regarding medicines, staffing and staff supervision.

Prior to the current inspection we reviewed the information we had about the service. This included information sent to us by the provider for rectifying the breach identified at the last visit and notifications of incidents that had occurred. We also spoke with two health and social care professionals about their views of the quality of care in the home.

This inspection took place on 17 February 2016 and was unannounced. The inspection was carried out by two inspectors and a specialist professional advisor who was a nurse with knowledge of older people's needs.

During the inspection we spoke with eight people using the service, three relatives of people using the service, a private carer and a health care professional visiting people living at the home. We spoke with the area manager, the service manager, the deputy manager, three nurses, four care staff, and an activities coordinator on duty. We looked at the care plans, risk assessments, and daily records relating to 11 of the 31 people who were living at The Arkley Nursing Home. We looked at eleven staff files (including recruitment records for seven new staff), the last month of staff duty rosters, accident and incident records, selected policies and procedures and 10 medicines administration charts for people using the service.

Good

Is the service safe?

Our findings

People living at the home and their relatives told us they felt safe at the service. They said that there had been a significant improvement in staffing numbers in the home, and a reduction in the use of agency staff. One person told us, "Staff support at night is a lot better." A relative said, "We feel safe here and have no complaints."

People and their relatives told us that they could raise concerns with staff or the management. Staff showed an understanding of the service's policy regarding how they should respond to safeguarding concerns. They had received training in safeguarding adults and knew who they should report to if they had concerns that somebody was being abused. We saw evidence that incidents were reported appropriately.

Risk assessments were in place to ensure that risks to people were minimised. There were detailed risk assessments for all identified risks including falls, pressure ulcers, weight loss and moving and handling. These were reviewed monthly or more often when needed, including a record of changes to the level of risk and actions identified to address them. Appropriate safety checks were in place for the home including fire safety, gas, and electrical safety certificates.

Staff had training in using the hoists to help transfer people, with different sizes of sling in place for different people as appropriate. We found that people's views were taken into account in assessing risks to them. For example, one person expressed their wish to have bed sides to feel secure at night, but did not want to use bumpers on the rails. There was signed consent in place for this action, with risks explained and understood. Staff we spoke with had knowledge of general first aid and emergency provisions within the home such as the presence of resuscitation equipment.

Since the previous inspection there had been considerable recruitment of permanent care and nursing staff to work in the home, with no agency staff used within the last two months. Three new care staff were on induction training at the home on the day of our visit. Three nurses worked in the day time, alongside seven care staff, with two nurses and three care staff at night. At the time of our inspection one person was receiving one to one care support in the day in addition to this.

People using the service, relatives and staff members all indicated that the staffing situation had significantly improved since the last inspection at which time there was a major reliance on agency staff. However, some people told us that they sometimes still had to wait for assistance. For example, two people said that staff could be quicker with providing continence support when they needed it, and one relative said that there were occasions when the home was short staffed.

Staff told us that they did experience staff shortages occasionally due to short-notice sickness, but they were able to cover with bank staff when this happened. On the day of the inspection staff were observed to be responding within a minute when the call bell sounded. A record was available of each person's ability to use the call bell system. Call bell response times were being collated for each day, with all calls answered in more than five minutes highlighted. Staff said checks were carried out every 30 minutes on those who were

unable to use the call bell, and there were hourly checks at night to monitor people's safety and comfort. We observed that call bell waiting times were much shorter than at the previous inspection, and there were recorded systems in place to investigate longer call times.

We requested data since the previous inspection of staffing hours per person each week in the home, as recorded by the provider. We found that there had been a further increase in staffing numbers per person (from 50.5 to 53.84 hours per week).

Appropriate recruitment procedures were in place to ensure staff were suitable to work with people. Staff had undergone the required checks before starting to work at the service. Files of new staff included disclosure and barring checks, two written references and confirmation of the staff member's identity. They also included interview records and checks on professional qualifications.

People told us that they received their medicines on time and were provided with pain-relieving medicines when needed. One person told us that they self-administered most of their medicines, and staff checked every night to ensure that they had taken them as needed.

Medicines including controlled drugs (subject to special storage and recording arrangements due to their liability for misuse) were stored safely and under suitable storage conditions. We found the temperatures of the areas where medicines were stored were monitored and recorded regularly and were within acceptable limits.

We found that there were suitable arrangements in place to record when medicines were received into the service, when they were given to people and when they were disposed of. Medicines administration records had been completed to show people had been given their medicines as prescribed and the records were consistent with the stock of medicines remaining. When people received their medicines in the form of a skin patch, records included clear details of the site of application to prevent damage to a person's skin if the same site was used repeatedly, as recommended at the previous inspection.

We found protocols were in place to guide staff on how to administer medicines prescribed on a "when required" basis, for example for pain relief, so that people were given the medicines consistently and correctly. We also found improved recording in people's care plans to indicate how people preferred to take their medicines. Medicine charts had appropriate pain assessment tools for those prescribed pain relief. Appropriate risk assessments were also in place for people who self-administered their medicines. Some people had their medicines crushed and given to them through a tube directly into the stomach as they had difficulty swallowing. There was a signed agreement by the pharmacist and GP for all such medicines to be administered in this way.

Management and staff told us, and training records confirmed, that staff authorised to handle medicines had been assessed that they were competent to handle medicines. Regular audits were undertaken to ensure that errors in administration or recording were picked up without delay.

People told us that the service was clean and we found this to be the case during the inspection visit. A relative told us, "Staff keep the environment very clean, with no smell." Cleaning charts were kept which showed that there were clear systems in place to ensure that all areas were cleaned regularly, including equipment such as wheelchairs, and periodic infection control audits were carried out. There were sharp boxes in place and nursing staff were aware of how to dispose of sharps and to prevent injuries when boxes were full.

Six rooms on the ground floor had recently been refurbished, and people spoke positively about the improvements made to these rooms. On the day of our inspection there was a local authority environmental health inspection of the home's kitchen. The kitchen walls and door frames were found to be in need of repair and redecoration. The area manager was aware of this issue as this had been picked up at a recent health and safety audit for the home. A request for the work to be carried out had been relayed to the provider.

Requires Improvement

Is the service effective?

Our findings

Most people spoke positively about the staff that supported them. They told us, "Staff know what they are doing and have the skills." However, three people living at the home and two relatives said that staff support could be variable. One relative noted, "Some staff are very willing, others less so; staff vary." One person told us that they had noticed some tensions between new and established staff working in the home.

We found some gaps in supervision provided to care staff in recent months. There had been recent supervision sessions for nurses, the chef, administrator, and housekeeper. Topics covered for nurses included time management, care planning, nutrition, medicines, pressure care, clinical responsibilities and wound management. However, the majority of care staff had not received individual supervision sessions for many months with their last supervision being a group session in August 2015. The new management team were in the process of re-introducing individual supervision sessions, and we observed records indicating three care staff had received recent supervision sessions.

Nursing staff said that they attended clinical meetings each week with management. They told us, "They give us a lot of support." Staff at all levels told us that they felt well supported by the management team, and described good team work, morale and communication within the team. One staff member described the management team as "firm but nice, and always out and about." A recent staff survey indicated satisfaction with the manager's effectiveness and the home's purpose and performance, but areas for improvement included taking action (24 percent satisfaction), recognition and performance (37 percent) and involvement and belonging (44 percent).

New staff received a week of induction training prior to working in the home. On the day of our visit, three new care staff were shadowing staff working in the home as part of their induction training. Induction training included dementia care, safeguarding, food hygiene, nutrition, pressure ulcer care, and managing behaviour that challenges. A mandatory-training matrix was in place for the service, indicating which staff had undertaken each training course, or were due to do so or have refresher training in this area. In February 2016 the overall compliance for the staff team was 87.3 percent. We noted that there had been a dip in training levels in the period until November 2015, but there had been significant training provision for staff in mandatory areas within the last two months.

Staff were positive about the standard of training. However, one nurse we spoke with had not yet undertaken emergency first-aid training, dementia or Mental Capacity Act training, and the majority of nurses had not yet undertaken syringe driver training. Management advised that this training was planned, and it was also intended that nurses would undertake leadership training to assist them in their role. However, we were concerned to learn that an activities coordinator who had been working at the home for eight months, having not worked in the care sector previously, had not received any mandatory or other relevant training. We brought this to the attention of the manager to address.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). This provides a legal framework for making particular decisions on behalf of people who may lack the

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

People said they were able to make choices about their care. We found that assessments were in place to comply with the MCA. Care records contained best interests decisions and made it clear as to whether people had capacity to make decisions. Staff had received training on the MCA. Staff interviewed were aware of the need to ensure that those with capacity were supported to make their own decisions and choices. This was achieved by the staff asking permission to carry out each task before commencing it and gaining their consent.

There were DoLS in place for two people living at the home. However, in both cases the care plans did not make reference to the fact that a DoLS was in place, and care and nursing staff were not clear as to who had a DoLS in place. We discussed with the management team the need to check if further DoLS referrals were required, particularly where people were unable to communicate their wishes as to whether they wanted to remain at the home. We also discussed the need to improve records of decision-specific MCA assessments and best interest decisions and DoLS to ensure compliance with the MCA.

There were clear records of people's advanced wishes and 'do not attempt resuscitation' forms, including bereavement plans for some people. Care plans included personalised information about how people wanted their care provided. For example, one person preferred to take their medicines with juice. Records confirmed that they took their medicines with thickened juice every morning.

All but one person spoken with were positive about the quality of food served in the home. They told us, "The food is quite good really," "The food is lovely," and "I can choose more since Christmas, there is now more choice." One person noted, "The meals are very nice and I have it on time. You can ask for more and there is always enough to eat and drink."

Breakfast was served to the majority of people in their own rooms. People we spoke with confirmed that this was their choice. People were offered choices at meal times, and there was an unhurried atmosphere in the dining area at lunch time. Lunch was well presented and staff sat and stayed with people to ensure they had enough support to eat their meals.

People's nutritional needs were assessed and when they had particular preferences regarding their diet these were recorded in their care plan. The chef was aware of the dietary needs of people who had diabetes or who were on particular diets. More choices had been added to the menus. People chose their meals the day before, and could choose an alternative if they did not like the choices on the menu.

Food and fluid charts were in place for people on a reduced dietary intake, or where concerns about their nutrition were identified, to monitor the amount of food or drink they consumed. Where necessary we saw that people had been referred to the dietitian or speech and language therapist if they were having difficulties swallowing. Nutrition and hydration was monitored by monthly weight records, reporting by care staff, fluid balance charts and food diaries. Appropriate systems were in place for people who received food via a PEG tube (directly into their stomach).

People confirmed that they had access to health care professionals, and we saw this documented in their

care records. The GP visited on the day of the inspection and we were told that he visited on a weekly basis. Arrangements were made for people to be reviewed by other health and social care professionals such as a physiotherapist, chiropodist, occupational therapist, social worker, dentist and optician. Arrangements were in place for a tissue viability nurse to attend to a person with surgical wounds. A diabetes specialist nurse visited a person with diabetes and made entries in their care record. The service made arrangements for people to either attend outside health care appointments or for specialist support to visit them.

We observed that instructions from health care professionals such as a tissue viability nurse (regarding pressure ulcer care) were followed by staff at the home. Clear records were maintained of the outcome of health care professional visits. During our visit one person experienced significant chest pain, and the nurse on duty called an ambulance without delay as appropriate.

Good

Is the service caring?

Our findings

People told us that they felt well cared for, and that they were treated with dignity and respect. Comments included, "They are most respectful", "Staff are nice and warm", "Staff are quite nice" and "I'm quite happy as I am." Relatives were also positive about staff. One relative told us, "Staff are nice and caring." Another relative said that the service was "outstanding" with staff who were "very caring, and fully involved in the care of residents." People felt able to approach staff with any issues of concern.

People told us that they were involved in producing their care plans, to ensure that their preferences were incorporated. Some of the care plans had been signed to indicate people's involvement including consent forms when needed. We observed that where appropriate people were supported to maintain their independence skills, for example in managing their own medicines.

One person told us that they were independent and preferred to look after their own personal hygiene needs and to self-administer their medicines. Their care plan had been created according to their wishes, enabling them to manage their care and medicines as independently as possible. They told us that they could ask for help when needed, and that staff provided support in the way that they wished. For example, staff would bring them hot water to make their own coffee, promoting their independence. Another person told us, "I feel involved in my care plan and there are useful outdoor activities to the history museum or West End."

One person told us that they were still closely in touch with a childhood friend who visited them regularly. They told us that they liked spending time with their friend at the care home. We observed that this person's friend was part of their care plan.

We saw staff being caring toward people living at the home. They spoke politely and were supportive to people. Staff said that they always ensured people's privacy and dignity was protected and respected especially when providing personal care. We observed that they knocked on people's doors and waited for a response before entering. Staff demonstrated an understanding of dementia awareness and how to care for particular people.

Photographs of people living at the home involved in activities were posted throughout the home, and bedrooms had been personalised providing a homely environment.

Staff understood people's needs with regards to their disabilities, race, sexual orientation and gender. Care records showed that staff supported people to practice their religion and attend community groups that reflected their cultural backgrounds. A religious service was available to people on a regular basis, and one person was supported to maintain strict cultural dietary requirements according to their wishes.

Good

Is the service responsive?

Our findings

At the previous inspection in May 2015 we found that people's care and treatment was not designed with a view to achieving their preferences and meeting their needs. Following the inspection, the provider produced an action plan to address this breach. During our current visit we found that improvements had been made in providing person-centred care to people living at the home.

People told us, "I'm quite happy", "If I had a problem I could talk to them" and "The managers pop in to check everything is okay." People who were in bed during the inspection told us that they did not want to get up out of bed any more than they did. People said that they did not get bored, although two people said that staff were frequently too busy to chat with them. Staff said that they tried to respond promptly within a minute when a call bell was sounded, alerted by the pagers they wore.

Regular care plan audits were being undertaken to ensure that records were completed promptly and accurately and reviewed at least monthly. Care plans included relevant risk assessments and plans to support people with their holistic needs including mobility, skin integrity, nutrition, social and emotional needs and communication. We found that care plans were personalised, including some detailed information about people's preferences. Care records included sections such as 'my day,' 'my life,' 'my portrait,' and 'a normal day,' and details of who people wished their information to be shared with.

The service used a system called "resident of the day" to concentrate on a different person living at the home each day, and review their care records, private accommodation, menus, activities and any maintenance issues affecting them. A staff member told us that one person, who had moved to the service for a respite stay, had now chosen to stay permanently. As a result they were working with this person to review their care plan.

We saw appropriate use of monitoring records including body maps to record any bruising or other skin marks, and records of people's weights, nutrition and hydration, and regular adjustment of position if required to protect them from developing pressure ulcers. However, daily notes recorded by staff did not include references to people's social and emotional wellbeing or activities or stimulation provided. A relative told us that although care was improving within the home, they had found some inaccurate information recorded in care records and had concerns about communication across the staff team. We passed these issues on to the manager, who undertook to work to address them.

The home offered a programme of activities including regular trips out of the service, which were popular. An activities schedule was posted on the wall by the main lounge. There were two activities coordinators working at the home. On the morning of the inspection, an activities coordinator visited each person in the morning with the tea trolley, to chat to them and get their menu choice for the next day.

People told us that they enjoyed the afternoon activities provided and entertainers who visited the home. They particularly enjoyed going out with staff, and had recently been to a pantomime and a museum. Records showed that other recent trips included trips to shopping centres, meals out, and a trip to the coast.

Activities included exercise sessions, word searches, games, bingo, and flower arranging.

The service was adopting various ways to engage with people who had varied needs, including use of an 'active minds box.' This was an activity box used by the activities coordinator to engage with people who were in bed or unable to join in group activities for another reason. The box contained large size puzzles, reminiscence image books, stress balls, chatter box cards from the 1950s, quizzes and painting books that could be accessed by people who were unable to hold pencils, pens or brushes. People with mild visual impairment were encouraged to use patterned puzzles. The home also had a trolley of sensory equipment for people to use. However, the care home did not have any audio books. We raised this with the activities coordinator, who advised that this was something they would explore.

People told us that they knew how to make a complaint, and felt that the management team listened to any concerns they raised. There was a notice displayed in the home explaining how to make a complaint, and recent resident and relatives meetings had been held at which people had an opportunity to raise their concerns. Records were in place of all complaints received since the last inspection, including details of action taken to address them. A relative told us that they had complained about the cleanliness of wheelchairs in the home, and that this had since improved.

One person told us that they had complained about salads provided in the home not being as varied as they would like them to be. Following this the deputy manager suggested that they create their own menu that can be given to the chef to prepare according to their wishes.

Good

Is the service well-led?

Our findings

People and their relatives told us that there had been significant improvements since the previous inspection, largely as a result of consistent management and staff recruitment so that there was no longer a reliance on agency staff. When asked about the management, people told us, "They listen", "They are around a lot" and "The area manager is very approachable."

A new manager and deputy manager had commenced work at the home in September 2015. There was also a new area manager who was closely involved in supporting the management team, and held in high esteem by people living at the home and their relatives. The manager was in the process of registering with the Care Quality Commission, providing continuity of management in the home which had not been in place for the last two years. The management team advised that they were currently not taking on more than one new admission each week, and were attempting to break down any remaining institutionalised practices in the home. They described strengths including medicines management, food provision and housekeeping, and areas for improvement including in the records of care and activities provided. The deputy manager was providing management cover to the home on some weekends.

Staff said they found the managers to be very supportive and visible all the time, and described a happy atmosphere in the home. They described shift handover meetings and staff meetings to discuss issues of compliance, address any shortfalls and receive feedback from managers. An activities coordinator mentioned that she found attending 'residents and relatives meetings' at the care home useful, as she was able to learn more about people and their relatives.

At the most recent residents (without relatives) meeting in December 2015, activities and outings had been discussed including consultation over whether people wanted to have a karaoke machine for the home. At the previous meeting in November 2015 housekeeping had been the main topic for discussion. Resident and relatives meetings were held approximately every two months. In January 2016 issues discussed included people's care and wellbeing , safety, meals, activities, refurbishment, lighting and staff attitudes. There was evidence that actions were taken as a result, for example lighting within the home was to be changes as a result of people's views.

There was a system of surveys and audits in place for the service, to ensure that areas for improvement were identified and addressed. A recent survey of people's views on the service was undertaken by Network Research in December 2015. The top three strengths of the home included staffing, people being content living in the home, and the warmth and friendliness shown by staff. Three main areas for improvement included the quality of care, staff availability when needed, and promptness of staff attending to people's needs. An improvement plan was in place for the home to address these areas.

The manager undertook a weekly walk around the service, recording areas for improvement. Most recently these included window and carpet cleaning, kitchen refurbishment and activities provision. The deputy manager conducted a daily walk around, including checking staffing, monitoring of people's changing needs, the environment, activities, and call bell answering. A daily meeting was held with staff from different

designations in the home to share information and bring about improvements. Records indicated that a recent meeting had included customer feedback about portion sizes, and discussion of the 'resident of the day.'

The deputy manager also conducted a weekly clinical walk around weekly and held a weekly clinical meeting with nursing staff. They covered pre-admission information, and changing needs in key areas such as tissue viability, nutrition and hydration, swallowing difficulties, and challenging behaviour. The provider used quality metrics to monitor its ongoing performance, with areas monitored monthly including pressure ulcers, weight loss, mortality, medicines errors, GP reviews, hospital admissions, safeguarding incidents and resident involvement.

Monthly medicines, and health and safety audits were conducted on each floor of the home, and approximately three care plan audits were conducted weekly. The most recent infection control audit was undertaken in December 2015. Incident and accident records were recorded with details about any action taken and learning for the service. Incidents and accidents were reviewed by the manager and action was taken to make sure that any risks identified were addressed.

A recent Healthwatch visit undertaken in November 2015 identified six areas for improvement including prompt answering of call bells, shift hand over records, residents meetings. As a result the management had produced an action plan including performance monitoring, staff supervision and meetings, and activities coordinators carrying out room visits.