Bupa Care Homes (ANS) Limited

Meadbank Nursing Centre

Inspection report

12 Parkgate Road
Battersea
London
SW11 4NN
Tel: 020 7801 6000
Website: www.bupa.co.uk/care-services/care-homes/meadbank-nursing-centre-london

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

Overall summary

The inspection took place over three days, on the 6, 10 and 12 November 2014. On the first day of the inspection we arrived unannounced.

Meadbank Nursing Centre is a large nursing home, providing care for up to 176 people. Most of those using the service are older people, including some who are living with dementia. The top floor specialises in caring for those with dementia, although all the units support some people with this condition. A few people receive a service for a short period (respite care), but most receive long term care.

The home met all the regulations we checked at our last inspection visit in September 2013.

Summary of findings

Although the home is purpose built, it has been added to over the years. Each area has been divided into units or suites overseen by a unit manager who is a registered nurse. The suites are named after different London bridges and the home is located near to the river Thames.

The Registered Manager was due to leave the company a few days after our inspection. He had been covering a more senior role just prior to his departure, so day-to-day management of the home was in the hands of the deputy manager and the clinical nurse manager, both of whom had worked within the home for many years. We saw that there was an advert out to recruit a new registered manager. 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.

There was evidence of good care throughout the home, but there were inconsistencies too.

The home was clean, with the exception of one lounge early in the morning, but the poor state of the external bin stores amounted to the breach of a regulation. You can see what action we told the provider to take at the back of the full version of the report.

Some parts of the building were overdue for refurbishment, but there were plans in place to address this. Signage and other means of helping people to find their way around were underdeveloped.

People's personal care needs, such as assistance with bathing and skin care, were well attended to, but there was less emphasis on meeting people's social and emotional needs. This was particularly important for those living with mental ill-health or dementia. We made a recommendation about this.

The management team was well informed about the Mental Capacity Act 2005 and applications for Deprivation of Liberty Safeguards had been made if people could not make their own decisions and restrictions had to be put in place to keep them safe.

Assessments, care plans and risk assessments were up-to-date and staff were well informed about people's individual needs and preferences. Meals were nutritious and well presented. People told us that the staff were kind.

We found that the home benefitted from good local leadership and there were robust systems in place to monitor and evaluate the care provided. The home had achieved recognition for the quality of its end of life care from the Gold Standard Framework.

Staff members were supervised regularly and received appraisals. The provider followed safer recruitment practices and ensured all appropriate checks were carried out prior to employment. As well as mandatory training and refreshers in areas of health and safety, staff members attended training in dementia care and had the opportunity to enhance or consolidate their professional qualifications. People told us that staff were kind and caring; there was only one exception to this which we reported to the managers so they could investigate.

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? The service was not safe in all aspects. This was because of the state of the external waste storage areas. Trained staff followed safe procedures for ordering, administering, storing and disposing of medicines. A core level of staffing was maintained and often enhanced to better meet people's needs.	**Requires Improvement**
Is the service effective? The service was not effective in all aspects. Signage and other ways of orientating people to their surroundings needed to be improved. There were gaps in fluid intake recording and inconsistencies in whose intake was recorded. The managers were well informed about recent legal changes to the application of the Deprivation of Liberty Safeguards and were in the process of assessing the implications for people who used the service. All staff received training appropriate to their role and there were opportunities to take national vocational qualifications. Food was nutritious and alternatives were offered, even when people changed their mind at the last minute.	**Requires Improvement**
Is the service caring? The service was caring. People who used the service said staff were kind. Staff spoke warmly about the people they cared for and we observed that they knew people's needs and preferences. The home had achieved "beacon status" within the Gold Standard Framework for end of life care.	**Good**
Is the service responsive? The service was not responsive in all areas. We have made a recommendation about responding to the social and emotional needs of people living with dementia or mental ill-health. Complaints and concerns were responded to promptly and managers were open about errors when they had occurred.	**Requires Improvement**
Is the service well-led? The service was well-led. Staff told us that local senior managers put people who used the service first.	**Good**

Summary of findings

There was systematic monitoring and evaluation of the care provided and the findings were analysed and shared with relevant staff members through a variety of meetings, each with a different focus.

Meadbank Nursing Centre

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 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.

This inspection took place over three days the 6, 10 and 12 November 2014 and was unannounced on the first day, when the inspection team arrived at 6.00am.

The inspection team comprised of two inspectors and a specialist advisor on the first day. The specialist advisor was a qualified social worker with experience of managing a wide range of registered care services. One inspector returned for the subsequent two days.

We spoke with 13 people who used the service and, if people were unable to speak to us, we observed them in the communal areas to assess whether or not they were comfortable with staff on duty and their surroundings. We also spoke with eight relatives or friends who were visiting the service during our inspection and one relative by phone.

We interviewed 19 staff members, this included the registered manager, the deputy manager, the clinical nurse manager, the maintenance manager, an activities coordinator, three unit managers, two nurses, six care workers, two kitchen staff and one member of domestic staff. We observed a daily heads of department meeting, a daily clinical briefing, a weekly clinical meeting and a shift handover meeting.

Due to technical difficulties, the registered manager had had problems sending the Provider Information Return (PIR), so we did not receive it prior to the inspection, but a hard copy was made available soon after arrival. We saw that every effort had been made to submit it electronically. The PIR 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 information from visiting professionals in advance and spoke with three of them. We reviewed relevant policies, procedures and records, including 10 care files and five staff files.

Is the service safe?

Our findings

One communal area was not clean but people who used the service were seated there before domestic staff arrived for the day; the arrangements for storing waste outside the home did not fully protect people from the risk of contamination. When we arrived unannounced at 6.00am the night staff were on duty. On arrival we found the top floor communal areas to be dirty. No one had cleared dropped food and tissues from the lounge where some early rising people were sitting.

We found the external bin stores, which were adjacent to a public right of way, were not clean and tidy. Some staff members were not putting waste bags neatly in bins, they were overfilling the most accessible bins, so waste had spilled out. This problem applied to the clinical waste bins, the recycling bins and the general waste bins. The situation was compounded by small (relative to the size of the home) external bins stores and the timing of the waste collections. We saw that the cleaning schedule covered the bin areas, but they needed more frequent attention. In addition, pallets and broken furniture for disposal were stored in the open and were accessible to the public pending their collection. This was an eyesore and staff members were using the area to smoke and sitting on these potentially dirty items in their clean uniforms. Staff told us that these were persistent problems.

The inadequate arrangements for waste disposal amounted to a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2010. This corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence of good infection control practice inside the building during our inspection. Staff washed their hands at appropriate times, personal protective equipment (PPE) such as gloves and aprons were readily available and well used. There was a good standard of cleaning in most areas with domestic staff working eight hours each day to maintain standards. Fridges in the kitchenettes on each floor had their temperatures recorded daily and they were within the required range. The kitchen had maintained its five star food hygiene rating (the top score) for a number of years. However, poor practice in two areas detracted from the otherwise positive view we gained of infection prevention and control.

People told us they felt safe and they had "no concerns" in this area. One person said, "Staff make me feel safe." One relative expressed concerns about some aspects of safety. When we checked, these were being followed up by the provider using safeguarding procedures.

We asked staff members what they would do if they had any concerns about a person's well-being, they all said they would report it to a member of the management team. Care staff were able to describe possible signs of abuse. A typical response was, "If I saw bruises, I'd report it to the unit manager and I'd write it down [in the person's care records]." We saw that managers had raised safeguarding alerts when necessary and cooperated with the local authority in investigations.

The provider had appropriate systems in place to obtain, administer, store and dispose of medicines safely. Only nurses administered medicines. We saw records that showed that nurses were subjected to checks to ensure their competency in the administration of medicines, including controlled drugs.

We checked the medicines administration records (MAR) on the second floor and they were correctly completed, with people's known allergies prominently displayed. Protocols were available for all 'when required' medicines. These advised staff of the signs and symptoms that indicated that the 'when required' medicines should be offered to an individual.

We observed one person being given their medicine in crushed form, the need for this was recorded and the medicine was prepared in front of them using their personal crusher. On at least one of the floors, staff were not recording the morning application of creams and lotions immediately as the folder for this was held in the unit's office. They delayed this until there was some quiet time during the afternoon, but this could increase the risk of inaccurate recording.

We found that risk assessments were in place where required and the care staff we spoke with were aware of the potential risks for each individual and knew how to reduce them. For example, there were procedures in place to try to prevent pressure ulcers for those who were at risk of developing them. A relative told us that since their family member had a fall, measures had been introduced to prevent a reoccurrence and staff were now aware of the risk.

Requires Improvement

Is the service safe?

Care staff rotas indicated that a level of core staffing was maintained and, often, exceeded. A mixed team of nurses and care staff worked on each floor. We noted that the provider had stopped using agency staff earlier in the year and managers told us this had improved continuity of care. Staff members told us it had been hard to cover every shift during the summer, but an incentive scheme had been brought in to encourage the regular staff to cover each others' absence and this was working well. People with an assessed need for one to one care received this from staff working for other providers. They were not directly employed by Bupa.

On our arrival the top floor was operating with its core level of night staff, but we observed them to be very stretched. There was no one available to attend to people who were already up and about as staff were busy in people's bedrooms. Staff told us they usually benefitted from an additional member of night staff and we saw from the rota that this was correct. We asked the managers to consider how the needs of early risers could be better met every day.

We saw that the provider practiced safer recruitment and there was evidence that all the required security and identity checks were carried out prior to appointment to ensure that staff were suitable to work with people using the service.

The heating had failed on the previous day so there was one fan heater in use in the corridor on the top floor when we arrived at 6.00am. One early-rising person was not warmly dressed until we pointed this out to staff, but others were appropriately dressed. Engineers had attended the previous day, but could not mend the heating immediately, however they returned later the next day and fixed the problem. Work to completely overhaul the heating system was planned. At the time of our inspection the temperature of the building was controlled centrally by the provider, this did not allow for any variation for individual circumstances.

A stairway between two parts of the top floor was being refurbished. In the meantime the carpet was a trip hazard for staff and people who used the service; we were told that people did not access the stairway independently and we saw it was protected by keypad locks, but it remained a risk and we asked the maintenance manager to attend to it.

Whilst some parts of the building were attractively decorated, other parts of the building were overdue for refurbishment, particularly the top floor, where the lounge carpet was heavily stained and the window in the 'woodland room' did not shut. In places more attention to the furnishings was required, for example, curtains drooped or failed to meet in the middle or chairs were placed around the walls, rather than in clusters to enable people to interact with each other. This detracted from the ambiance of some of the rooms. The managers told us of the improvements the provider was planning, but they were not in place at the time of inspection.

Requires Improvement

Is the service effective?

Our findings

A relative said, "Staff seek mine and my [family member's] permission for everything."

We found that the service was meeting the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Senior managers were very well-informed about the recent Supreme Court ruling which widened the scope of DoLS and were systematically reviewing whether or not there were implications for any people who used the service. They were only part way through this process, but we saw that 29 referrals had recently been made in relation to the use of bedrails for people who may lack capacity to consent to their use. For those people whose needs had already been reviewed, best interests meetings had been held, assessments of decision-making capacity had taken place and DoLS applications had been made to the relevant local authority when appropriate. Documentation was clear and unambiguous.

The provider kept up-to-date training records which showed that all but the newest staff had completed their mandatory induction and refresher training and attended short courses on the care of people living with dementia. Two care staff were able to provide us with extensive information about what they had learned on this course and through their day to day work experience. Care staff told us that they had the opportunity to study for national vocational qualifications in health and social care and nurses said that there was a preceptorship programme in place. The aim of the preceptorship programme was to enhance the competence and confidence of newly registered nurses.

Staff received individual regular supervision for which records were kept. We also saw records of group supervision which had been held to discuss specific issues. This enabled them to keep up to date with best practice and to discuss their own needs as well as the needs of people who used the service. A system of annual appraisals was also in place.

A relative told us that one of the kitchen staff had made a "huge effort" to encourage their family member to eat, tempting them with their favourite steak and lamb chops. We observed that two people who required special diets were served with them at lunch time. We noted that the food served during our inspection was nutritious and presented attractively. One person changed their mind at the last minute about the meal they had chosen, they were offered an omelette or sandwiches instead.

Fluid charts were in use for some people with complex needs. We found that these were usually well maintained, but there were some gaps in recording. Some people who could not access their drinks independently did not have their fluid intake recorded. This could present a risk of dehydration if their communication or memory were also impaired. We asked the managers to check the consistency of the home's approach.

Signage was underdeveloped, as was use of objects of reference (items which have a particular meaning to people and can help to orientate them). We did not observe staff making use of those which were in place, for example, by pointing them out to people as they accompanied them along corridors. Improvements in these areas would help those who were living with dementia to find their way around.

Most people who used the service were registered with a GP practice which was retained by the provider. They carried out monthly rounds and conducted medicines reviews, they also visited people by appointment at other times. GP notes were available in people's care files. There was evidence that people regularly accessed other healthcare professionals, for example opticians visited the home. The provider employed a physiotherapist who ran some exercise groups, managed wheelchair reviews and repairs and liaised with hospital and community based colleagues to meet people's physiotherapy needs.

Good

Is the service caring?

Our findings

People who used the service had positive views about the care provided. One person told us they were “Very content and well looked after.” Another described staff members as “brilliant and very friendly” and yet another said, “This is an amazing place; the staff are fantastic and the communication is very good.”

A healthcare professional who visited the home regularly told us they had actively considered it for their relative and had only ruled it out for geographical reasons. The relatives we spoke with during the inspection were mainly positive about their family members’ experience, as were people’s friends. A typical comment when asked about the standard of care was “It’s absolutely brilliant.” Three relatives or friends were less positive, but when we checked we saw that their specific concerns were being followed up appropriately.

We saw that staff were attentive to individuals’ needs and preferences, for example, when they observed that one person was not their usual self, staff went through a process of elimination to identify the problem because the person was unable to communicate their needs. During this they demonstrated their knowledge of what was likely to upset the person. A member of staff said, “[It’s] important to get to know each person as an individual.” Early rising people on the top floor would have benefitted from more staff support and supervision prior to breakfast.

When we spoke with nursing and care staff they talked about those they cared for in a warm and positive way. Several commented that they thought of people who used the service as part of their own extended family and wanted to do their best by them. We observed good quality interactions between staff and people who used the service. Some communication may have been enhanced if communication aids were more in use. Staff members were also observed being supportive and caring towards family members. Dignity and privacy were respected, for example, staff addressed people politely and closed bedroom doors before delivering personal care.

Although, one person told us they sometimes had to wait “some time” for staff to appear after they had rung their call bell and said this was because staff were “very busy”, we found that care staff were fully aware of the need to respond promptly to bells. One staff member described how they put call bells within people’s reach when they left them alone in their bedrooms. When we checked we found that bells were appropriately placed. A member of staff from the housekeeping team said they were encouraged to tell the unit manager if they thought that people waited too long for their bells to be answered. We saw that response times were centrally monitored and feedback was passed to the units.

We saw that the provider had made a particular effort to ensure staff, many of whom were not working in their first language, knew the appropriate terms to use when describing people’s needs, with the focus on what they could do for themselves, rather than what they could not do.

The home had achieved “beacon status” within the Gold Standard Framework (GSF) for end of life care. A healthcare professional, who supported them with this, described the leadership on this area of work within the home as “absolutely brilliant”. Following the GSF ensures that people receive good quality care at the end of their life. When we observed the heads of department meeting, the unit managers present spoke knowledgeably about all the steps involved.

There were opportunities for people who used the service to get involved in discussions about the care provided. Minutes were available from residents and relatives meetings. Maintenance of the building was a recurring theme and we saw that local management were following up these issues with their head office.

Requires Improvement

Is the service responsive?

Our findings

A person who used the service told us, “I have no complaints, but if I did I would speak to the unit manager.”

Two people who used the service said that they wished that they could get up or go to bed at slightly different times. They told us they had not mentioned this to staff, as they felt obliged to fit in with the home’s routine. One person said, “They [the staff] are very busy and others need the help more than me.” We raised this with the management team who said they would explore the issue further.

We spoke with one of the activities coordinators who showed us the monthly schedule of group activities, they said that people who used the service and their family members were encouraged to make suggestions. As a result of this, cookery sessions were about to be added to the schedule. We saw there was also capacity to provide some one to one activities for people who could not leave their bedrooms or who preferred not to participate in groups. We saw one person having their nails painted as part of a one to one activity. Two computers were available for use and they were set up to enable people to Skype (make video calls) to keep in touch with friends and family. Wi-Fi was available in some parts of the home and coverage was being extended.

We were told that people from different floors of the home joined together for activities. Whilst this was beneficial for most, two members of staff said that those on the top floor with complex needs arising from dementia sometimes found it disorientating to leave their unit. They suggested that their needs would be better met if more group activities could be carried out within the unit.

For those living with dementia or mental ill-health, there was insufficient support available to help people to interact with others and to engage in meaningful activities. Members of care staff knew what they needed to do, but we did not observe it taking place; one member of staff told us that they wished they could spend more time on people’s social and emotional care. Although the activities coordinators were able to attend to some people’s social needs, we found there was little focus on enhancing people’s social and emotional well-being in comparison with the emphasis on completing personal care tasks. Dementia care, in particular, was underdeveloped as a result.

Assessments of need and associated care plans were in place for people who used the service, they covered personal and nursing care, but there was little emphasis on social and emotional care and the documents were written mainly for staff use rather than being person centred; the style and content were not easily accessible for the person receiving the care. However, we found that staff were well-informed about people’s physical care needs as updates were passed on in shift handover meetings.

We observed that one person spoke a particular language and they were supported by a member of staff who spoke the same language at lunchtime. We checked how the home supported equality and diversity and we were told of a recent celebration held on the premises. A member of staff explained how managers had adapted some of their duties to take account of their disability. Another staff member commented that the home took pride in recruiting people with a wide range of ability.

We read the home’s complaints and compliments file. Responses to complaints were open and transparent with managers admitting to errors when these had occurred. The themes arising from complaints were detailed in the provider’s “quality metrics report”. When we observed a meeting for heads of department we heard discussion of concerns that had been raised. Associated actions were allocated and checks were made to ensure that previous actions had been carried out.

We recommend that the provider seeks advice from a reputable source to help them to provide personalised care that is responsive to the social and emotional needs of people living with dementia or mental ill-health.

Good

Is the service well-led?

Our findings

The local senior management team was passionate about the well-being of people who used the service. A member of staff said, "[The deputy manager] is really there for the residents."

We found the management team to be open about the challenges the home faced. They were accessible to staff and visitors at all times and promoted a positive culture within the home. Despite the size of the home, senior managers were very well-informed about each person's needs. When we asked them specific questions about the care of some individuals they spoke accurately about their needs. When they walked around the home they demonstrated excellent examples of interaction with people who used the service to staff. There was evidence that when safeguarding issues were identified or other concerns were raised, they were dealt with promptly. Where there were delays, the reason for this was recorded. However, a few issues which should have been prioritised were not, such as waste disposal and dementia care.

Staff received regular feedback on their performance through supervision. When it was poor, remedial action was taken and there was evidence in staff files of close monitoring of staff members who were underperforming. Appraisals were taking place regularly, although managers were a little behind their own schedule, due to the registered manager undertaking duties within the wider company.

The provider required the home to supply information about key metrics (performance indicators) for quality assurance purposes. We saw that the analysis of the key metrics was used by managers to prioritise and focus their work and their messages to staff. For example, we saw minutes which demonstrated that a variation in the small number of people with pressure ulcers was discussed.

There was a records review system in place. We saw that managers had reviewed 13 people's care plans in September and 16 medicines administration records. The provider's area manager visited regularly to carry out a quality audit; an analysis of falls had secured one to one staffing for one person to minimise the risk. The provider also had an on-line system for recording incidents and accidents which prompted the registered manager to send notifications to the Care Quality Commission when the reporting threshold was reached.

We observed a shift handover meeting. It was conducted efficiently and was informative; the staff coming on duty were allocated to attend to people in particular rooms and they had up-to-date information about their well-being and their plans for the day ahead. Other meetings, such as the weekly clinical one, were regularly held with different groups of staff; minutes demonstrated that key information was passed on and actions were followed up.

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 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Service users, staff members and the general public were not protected against the identifiable risks of acquiring a healthcare associated infection because of the lack of maintenance of appropriate standards of cleanliness and hygiene in relation to the external bin store and the adjacent broken furniture. Regulation 12(1)2(c)(I) This corresponds to Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.