Bupa Care Homes (ANS) Limited

St Mary's Nursing Centre

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced inspection on 20 July 2015.

The service provided care and treatment to adults, some of whom may be living with a variety of needs including chronic health conditions, physical disabilities and dementia. At the time of the inspection, 26 people were being supported by the service.

The service has a 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 were risk assessments in place that gave guidance to staff on how risks to people could be minimised. There were systems in place to safeguard people from harm.

The provider had effective recruitment processes in place and there was sufficient, skilled staff to provide the care people required.

Summary of findings

Staff received supervision and support, and had been trained to meet people's individual needs. They understood their roles and responsibilities to seek people's consent prior to care being provided.

People were supported in a timely manner, by caring and respectful staff. They were also supported to access other health and social care services when required.

People's needs had been assessed, and care plans took account of people's individual needs, preferences, and choices. However, people sitting on their wheelchairs for long periods increased the risk of them developing pressure area damage to the skin.

The provider had a formal process for handling complaints and concerns which in the majority of cases, were resolved to people's satisfaction.

The provider encouraged feedback from people and acted on the comments received to improve the quality of the service.

The provider had effective quality monitoring processes in place. However, some of the care records were not always up to date.

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 safe.

People felt safe and there were systems in place to safeguard them from harm.

There were robust recruitment systems in place and there was sufficient, skilled staff to support people safely.

People's medicines were managed safely.

Good

Is the service effective?
The service was effective.

People's consent was sought before any care or treatment was provided.

People were supported by staff that had been trained to meet their individual needs.

People were supported to access other health and social care services when required.

Good

Is the service caring?
The service was caring.

People were supported by staff that were kind, caring and friendly.

Staff understood people's individual needs and they respected their choices.

Staff respected and protected people's privacy and dignity.

Good

Is the service responsive?
The service was not always responsive.

People's needs had been assessed and appropriate care plans were in place to meet their individual needs. However, people sitting on their wheelchairs for long periods increased the risk of them developing pressure area damage to the skin.

People were supported to pursue their hobbies and interests. However, the lounge did not provide a comfortable environment for people to relax and socialise in.

The provider had an effective system to handle complaints, but these had not always been resolved to everyone's satisfaction.

Requires improvement

Is the service well-led?
The service was not always well-led.

The registered manager was supported by the area manager to provide leadership and stability.

Requires improvement

Summary of findings

People who used the service and their relatives were enabled to routinely share their experiences of the service and their comments were acted on.

Records were not always robust and kept up to date.

Quality monitoring audits were completed regularly and these were used effectively to drive improvements.

St Mary's 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 20 July 2015, and it was conducted by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service, including the notifications they had sent us. A notification is information about important events which the provider is required to send to us.

Prior to the inspection, we spoke with the commissioners of the service from the local authority when we met to discuss the concerning information we had received from a member of staff. During the inspection, we spoke with five people who used the service, five relatives, the registered manager, the area manager, the activities coordinator, two nurses and three care staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care records for six people who used the service, the recruitment and supervision records for six staff and the training records for all the staff employed by the service. We also reviewed information on how the provider handled complaints and how they assessed and monitored the quality of the service.

Good

Is the service safe?

Our findings

People told us that they felt safe, and a relative of one person said that their relative was in a safe environment. They also said that it had not been the case in the past, but they had seen a lot of improvements, adding, "I was worried about their safety then and we were here all the time." We established that this comment related to a time over a year ago, before the current manager was appointed. However, we had also seen significant improvements to how people's care was being managed. Another relative supported this view when they said, "I'm here all the time and I've never been concerned about the carers."

The provider had up to date safeguarding and whistleblowing policies that gave guidance to the staff on how to identify and report concerns they might have about people's safety. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace. Information about safeguarding was available for staff to refer to when needed and it included contact details for the relevant agencies. Staff had also received training in safeguarding people. They demonstrated good understanding of these processes and were able to tell us about other organisations they could report concerns to.

The care records showed that care and support was planned and delivered in a way that ensured people's safety and welfare. There were personalised risk assessments for each person to monitor and give guidance to staff on any specific areas where people were more at risk. The risk assessments included areas associated with people being supported with their mobility, risks of developing pressure area skin damage, falling, not eating or drinking enough. This maintained a balance between minimising risks to people and promoting their independence and choice. The risk assessments had been reviewed and updated regularly or when people's needs changed so that people received the care they required.

A record of accidents and incidents was kept, with evidence that appropriate actions had been taken to reduce the risk of recurrence. There were processes in place to manage risks associated with the day to day operation of the service so that care was provided in safe premises. There was evidence of regular checks and testing of electrical appliances, gas appliances, the lift, lifting equipment, such as hoists, and fire fighting equipment. The fire risk assessment had been updated in September 2014.

People and their relatives said that there was generally enough staff to support them safely. One relative said, "There are enough staff at the moment. It is ok." Comments made by two other relatives indicated that this was not always the case. However, these comments did not support the evidence that showed that there was adequate staff to provide the support and treatment people required.

The provider had an ongoing recruitment programme so that they covered any vacancies as they occurred. The manager told us that they had no vacancies for care staff, but they had to get nurses from an agency to cover some of the nursing vacancies they had. We noted that the provider had effective recruitment processes and systems to complete all the relevant pre-employment checks, including obtaining references from previous employers, confirmation of registration with the Nursing and Midwifery Council (NMC) for all nurses and Disclosure and Barring Service (DBS) reports for all the staff. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed.

People's medicines were managed safely and administered by nurses, apart from moisturising creams that were applied by care staff while supporting people with their personal care. Most people told us that their medicines were given as prescribed. One relative said, "[Relative]'s medicine is always on time and they do it right." However, another relative felt that slight delays at times, often resulted in their relative becoming anxious as they had been used to getting their medicines at specific times while living at home. The manager assured us that they would review this to alleviate the person's occasional distress. The medicines administration records (MAR) had been completed correctly with no unexplained gaps and medicines were stored securely. There was a system in place to return unused medicines to the pharmacy for safe disposal. Audits of medicines and MAR were completed regularly as part of the provider's quality monitoring processes and any issues identified were rectified promptly.

Good

Is the service effective?

Our findings

People and their relatives told us that staff were well trained for their roles and provided the care they required. One relative said, "It is good because we have built up good communication with the nurses and carers."

The provider had a training programme that included an induction for all new staff. The manager kept a computerised record of all staff training so that they could easily monitor when updates were due. However, this record was not up to date, although the manager was able to show us that all staff completed the training that the provider considered to be essential or had been booked on a future date. Staff we spoke with said that the training they had received was sufficient to enable them to carry out their roles. One member of staff said, "I have done all my training. I have done the NVQ Level 2 and I am now doing my Level 3."

Staff told us that they had regular supervision and there was evidence of this in the staff records we looked at. These meetings were used as an opportunity to evaluate each member of staff's performance and to identify any areas they needed additional support or training in. One member of staff said, "I get regular supervision and it's ok. We discuss my work and what training I need. I feel I get the support I need."

People were supported to give consent before any care or treatment was provided. Staff understood their roles and responsibilities in relation to ensuring that people consented to their care and treatment. There was evidence that where a person did not have capacity to make decisions about some aspects of their care, mental capacity assessments had been completed and decisions made to provide care in the person's best interest. This was done in conjunction with people's relatives or other representatives, such as social workers.

Where necessary, Deprivation of Liberty Safeguards (DoLS) had been applied for and authorisations received from the local authority so that people were appropriately protected in accordance with the requirements of the Mental Capacity Act 2005 (MCA). This included safeguarding people who were not able to leave the home unaccompanied by staff, so that the measures in place to protect them from harm did not place unnecessary restrictions on their freedom.

There were mixed views about whether people enjoyed the food. The overall view was that food was mainly good, but could be improved. One person said, "The meat is often really tough." Another person said, "There is too much sponge and custard, and not enough variety." Others felt that what was written on the menu was not always what was on offer. A relative who visited the home regularly gave an example that they hand seen 'milkshakes' and 'fruit' on the menu list, but they had never seen those being offered to anyone. Another relative said, "Food used to be better, they've cut costs and the quality has gone down. However, everyone agreed that the food was hot when served and there was some choice. We observed a lunchtime meal and noted that the food appeared well cooked and was presented in an appetising way. Also for a nominal fee, visiting relatives could have lunch with their relatives. Staff gave support to people who were unable to eat their meals without assistance in the dining room and also to those who had their lunch in their bedrooms. In addition to the main meals, people were also regularly offered snacks and hot or cold drinks. There was evidence that people who were at risk of not eating and drinking enough were monitored and appropriate action was taken to ensure that they maintained their health and wellbeing.

People told us that they were supported to access additional health and social care services, such as GPs, dietitians, chiropodist and dentists so that their health needs were appropriately met. Records also indicated that the provider responded quickly to people's changing needs and where necessary, they sought advice from other health and social care professionals. One person said, "If I need the hospital the home arranges it all. I don't have to do anything." Another person said, "There is a clinic next door for diabetes, so that is easy for me to get to." Two people said that they chose to go out for optician appointments rather than see the one who visited the home as they found this to be a cheaper option.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were kind, caring and treated them with respect. One person said, "They are very nice and very caring, but it's not like home." Another person said, "The night staff know that I like a cuppa and so they give me one whenever they have time." Other comments included, 'They are very good here, they really look after [relative', 'Look, we have photos of the carers, the main ones. They all fuss around [relative], they are really good'.

We observed positive interactions between staff and people who used the service. Staff were kind and caring towards people. There was a happy and friendly atmosphere throughout the home. While supporting people, staff gave them the time they required to communicate their wishes and it was clear that they understood people's needs well to enable them to provide the support people required. We observed that people particularly enjoyed the company of the activities coordinator, who had spent part of the morning painting some of the female's nails.

Some people and their relatives told us that they had been involved in developing their care plans and everyone said that they had been involved in reviewing the care plans. One person said, "We have reviews of what they are doing from time to time." Another person said, "I am involved in reviewing my care plan. I talk about it with them [staff]." A relative said, "I am very involved in [relative]'s care. I know what they do for [relative] and how they do it."

People told us that staff provided care in a way that respected their dignity, privacy and choice. We noted that people's preferences were respected. For example, one person said, "Sometimes I just like to be on my own and the carers are really good at noticing that and they leave me on my own for a while." One member of staff said, "Mr X does not like to be called by his first name. If you call him Mr X, he will talk to you a lot more and you will get more out of him. That is what we do." Also, people could go to bed or wake up at a time of their choosing. People's relatives or friends could visit them whenever they wanted. We spoke with relatives who visited the home regularly, including those who visited daily and they were happy that there were no visiting restrictions. One person said, "Friends and relatives can visit whenever they want to. They are always offered tea when the trolley comes round." We found this enabled people to maintain their social networks and relationships with loved ones.

Staff also demonstrated that they understood the importance of respecting people's dignity and gave examples of how they would do so while providing personal care. One relative said, "They always shut the door when they are providing personal care. I'm not allowed to stay in." Another relative said, "When the carers come in, I go out." Staff were also able to tell us how they maintained confidentiality by not discussing about people who used the service outside of work or with agencies who were not directly involved in people's care.

Information was given to people in a format they could understand to enable them to make informed choices and decisions. Some of the people's relatives or social workers acted as their advocates to ensure that they understood the information given to them and their views were acted on so that they received the care they needed. Information was also available about an independent advocacy service that people could access if required.

Requires improvement

Is the service responsive?

Our findings

Prior to the inspection, we had received concerning information that people might not have been receiving safe and responsive care at night. Checks by the local authority and a nurse from the local Clinical Commission Group (CCG) had not identified any major concerns and we did not see any evidence of this during the inspection.

We observed that the lounge did not provide a comfortable environment for people to relax and socialise in. The décor was bland, with very little to stimulate people. Also, there were not enough comfortable chairs for people to sit on. Only one of the five people who used wheelchairs to get to the lounge was offered and supported to sit in a high backed chair. We found this increased the risk of people developing pressure area damage to the skin. One person said, "I stay in my wheelchair all day. I've got a pressure cushion, but I now like to go into bed at 4pm to relieve the pressure." Although the manager told us that most people chose to sit on their wheelchairs, there was no evidence of this in the records we looked at. Also, we observed that people were having their lunch sitting on their wheelchairs and we did not see staff offer to support them to sit on the dining chairs. The manager told us that they would take urgent action to improve this.

People who used the service had a wide range of support needs. These had been assessed and appropriate care plans were in place so that they were supported effectively. People's preferences, wishes and choices had been taken into account in the planning of their care and had been recorded in their care plans. One person said, "The carers here work very, very hard to look after people well." There was evidence that care plans were reviewed regularly or when people's needs changed. Staff told us that they had got to know people's needs very well and each person was treated as an individual so that they received the care they expected and wanted. However, some people said that they were not always supported each time staff attended to silence the call bell. One person said, "They are good at responding quickly, but if they are busy, they come and check and then come back when they are free." One relative said, "I have waited up to 15 minutes, at times."

People were encouraged and supported to pursue their hobbies, interests and socialise with others within the home. We saw evidence that a variety of activities were provided by the activities coordinator and that a number of people took part. One person said, "I do like activities. I love to join in where there is something going on." Another person said, "I go to bingo." However, we noted that the activities coordinator worked for four weekdays each week and people told us that there was not much provided in their absence. One person said, "The activities coordinator is great, but there's only her. Not enough." Another person said, "It would be nice if there was a bit more going on." Some people also said that the group activities were always limited in the number of people who could take part because the size of the room meant that they could not accommodate many wheelchair users. Some of the people were also regularly taken out for shopping and meals by their relatives. One relative said, "We like to take [relative] to the local shopping centre." Comments by people who used the service included, 'I went out last Friday on the bus. Oh, I loved it', 'I can go out in the evening too. If I am going to be back late, I just tell them so they can let me in at the gate. It isn't a problem', I can video chat with my daughter on the computer as they have wireless internet connection at the reception'.

The provider had a complaints policy and procedure in place and people were aware of this. People told us that they would feel comfortable raising any concerns they might have about the care provided. Most people told us that they had not made any complaints, but we spoke with a relative who had raised a number of complaints about how their relative was being cared for. Records showed that they had made 10 of the 22 complaints recorded in the last 12 months. There was evidence that the manager had dealt with each of these complaints, but not always to the satisfaction of the complainant. The relative had discussed with us the issues they had complained about because they had not been happy with the explanations given by the manager. We fed this back to the manager and they said that they would readdress the issues with the relative so that they could achieve a permanent resolution.

Requires improvement

Is the service well-led?

Our findings

Robust records had not always been kept in relation to people who used the service. The records where care staff wrote that they had applied creams when they had supported people with their personal care had not always been completed fully. This information was also not always recorded in the daily records. This meant that there was not always evidence that creams that can reduce the risk of skin damage had been applied. A relative of one person said that they did not feel that people's records were always detailed enough. They said, "Often carers just write 'full care given', what does that mean? It isn't helpful to them or anyone who provides care after them." The provider also had recently changed their care planning documentation and two systems were being used, while staff were in the process of changing all records to the new system. This increased the risk of confusion, particularly while the staff were getting used to the layout of the new records. The local authority had also expressed a concern about the potential risk of a decline in the quality of care due to the introduction of a new process.

The service has a registered manager. People we spoke with knew who the manager was and they all felt that they could speak to her. A person who has lived at the service for a few years said, "She's the best manager we have had yet." Another person said, "The level of stability here is so much better. The manager has built up a regular bank of nurses and carers and this has created stability within the home." Staff told us that the manager was helpful and provided stable leadership, guidance and the support they needed to provide good care to people who used the service. We saw that regular staff meetings were held for them to discuss issues relevant to their roles so that they provided care that met people's needs safely and effectively. One member of staff said, "We have regular staff meetings and I find it very helpful. We talk about the care we provide to people and about other things to do with the home."

People and their relatives said that they could speak to the manager at any time, without a need to make an appointment. There was evidence that the provider worked in partnership with people and their relatives, as well as, health and social care professionals so that they had the feedback they required to provide a service that was safe and appropriately met people's needs. Quarterly meetings were held with people who used the service and their relatives, but these were not always well attended. One relative said, "The last meeting we had was for relatives and residents together and that worked well. Everyone could have a say." However another relative did not see the value of the meetings because they did not feel that the provider had a genuine interest in listening to their views and suggestions. They said, "We used to go to all of the meetings, but we have given up because they are a waste of time. Can't see the point in them." The provider also completed annual surveys of people who used the service, their relatives and professionals that worked closely with the service. The results were collated into a report and an action plan had been completed to address any areas identified as requiring improving.

The manager was also involved in local forums aimed at improving the quality of care for people who used the service. They also shared good practice and learning with other local care providers, local commissioners and professionals. They attended 'nursing home providers' meetings and they also met regularly with representatives from the local authority and those from the local Clinical Commissioning Group (CCG).

The provider had effective systems in place to assess and monitor the quality of the care provided. The manager completed a number of quality audits on a regular basis to assess the quality of the service provided. These included checking people's care records to ensure that they contained the information required to provide appropriate care. Other audits included checking how medicines were managed, health and safety and other environmental checks, staffing, and others. Where issues had been identified from these audits, the manager took prompt action to rectify these. The manager also produced and sent a monthly report to the provider. Quarterly audits had also been completed by the area manager. There was evidence of learning from incidents and appropriate actions had been taken to reduce the risk of recurrence.