Bupa Care Homes (BNH) Limited

The Arkley Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 13 June 2017 and was unannounced. This inspection was a focussed inspection following up on breaches in legal requirements we found at our last comprehensive inspection on 10 January 2017. The provider had written to us after the last inspection telling us how they would meet these requirements. On this inspection we found some improvements had been made in staff supervision and person centred care, but sufficient improvements had not been made in consent or governance, meaning the service was still in breach of legal requirements.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection by selecting the all reports link for this service on our website at www.cqc.org.uk.

The Arkley Care Home is a nursing home providing accommodation with personal care and nursing care for up to 61 people. At the time of our inspection there were 44 people living there.

The service did not have a registered manager in post; a condition of the registration of the service was to have a registered manager in post at the service. There was a manager registered with the service but they had left their post in February 2017 and were no longer working in the service. 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.

Medicines were not managed safely. We saw multiple issues with stocks of medicines not matching what the recorded stock was, medicines being given at the wrong time, medicines being disposed of unsafely and pain medicine for one person running out. We saw some evidence of good practice on one of the floors of the home where medicines were stored tidily and Medicine Administration Records were complete.

Documents around a person's known risk of bruising were not in place to assess or mitigate the risk to this person of further bruising.

We found a continuing breach in the governance of the home. Gaps and inconsistencies in consent documents had not been picked up in care plan audits, and the extent of the medicines issues had not been identified by weekly or monthly medicines audits.

The home was not always in keeping with the principles of the Mental Capacity Act 2005. There were gaps in consent documents. Inconsistencies that were found at the last inspection were still found and sufficient improvement had not been made in this area.
Staff supervisions were now taking place and staff felt supported by the new home manager.

People were receiving person centred care and information about people's needs had improved in files.

However not all files had the same level of individualised care recorded.

Complaints recording and handling had improved. People felt confident to complain to the manager and that they would be listened to. Complaints records were in keeping with the provider's policy.

There were overall three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Amounts of medicines did not always add up to what should have been in stock. Indicating incorrect amounts of medicines may have been administered. Records for time sensitive medicines did not always show when they were administered. Pain relief for one person receiving palliative care was not managed effectively in the days leading up to their death. Nurses administering medicines did not always follow best practise guidance. Risk management around a person's bruising was not in place.

Is the service effective?

Requires Improvement

The service was not always effective. We found improvements in the frequency of supervisions. Staff said they found supervision helpful and felt supported.

Despite finding improvements in applications for Deprivation of Liberty Safeguards (DoLS), we found gaps and inconsistencies in consent documents and the service was not always following the principles of the Mental Capacity Act 2005.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. The service had made some effort to be more person centred. There were still some gaps in care plans around people's preferences but we saw improvements.

Complaints management had improved with complaints recorded on a central log and followed up as per the provider's policy.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Audits were not robust enough to pick up concerns in medicines or consent. There was not a registered manager in post at the time of our inspection.

Staff said they felt supported.

The Arkley Care 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 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.

We undertook an unannounced focused inspection of The Arkley Care Home on 13 June 2017. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection 10 January 2017 had been made. We inspected the service against four of the five questions we ask about services: is this service safe, effective, responsive and well-led? This is because the service was not meeting legal requirements or required improvement in relation to those questions. The inspection was also prompted in part by notification of an incident which indicated potential concerns about a wider risk of unsafe medicines management.

The inspection team consisted of two adult social care inspectors, a pharmacist 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.

Prior to the inspection we gathered information on the service from previous inspection reports, information the provider had sent us in the form of notifications where we are told of important events at the service, and feedback from key stakeholders.

We spoke with eight people who used the service, six of their relatives, and interviewed three care staff and nurses and the home manager. We counted medicines stocks, examined their storage, and looked at medicine administration records and medicines policies and audits. We also looked at 11 care files plus records and policies relating to person centred care, supervision, consent, and governance.

Inadequate

Is the service safe?

Our findings

We looked at whether medicines were managed safely after being informed of a medicines incident that suggested there was a wider risk posed in the management of medicines.

On our arrival at 9.30am we observed two medicines trolleys were left unattended and unlocked on the ground floor and first floor for up to four minutes away from where medicines were being administered. We later saw this again between 10:35am and 10:40am, the medicines trolleys were left unattended and could have been accessed by an unauthorised person.

The medicines fridge on the ground floor was found to be open. Next to someone's insulin were two urine specimens. The nurse in charge explained these had only been placed in there for a short period of time. The specimens were labelled for the same person and dated and timed for the evening before and the morning of the inspection, indicating one of the samples had been in the medicines fridge overnight. We asked if there was a specimen fridge and the nurse confirmed there was not. This meant that samples that may have posed a contamination risk were stored next to medicines. The day after the inspection the home manager confirmed a new specimen fridge had been ordered.

Controlled drug returns were processed via a doom kit before return through a waste contractor. The two doom kits that were awaiting collection had not been dated or activated correctly according to the provider policy or manufacturer's instructions. A large quantity of controlled drug pain patches and an ampoule were in a liquid above the activated gel layer which was easily accessible if the lid was taken off. Therefore these drugs were not disposed of safely. We asked the nurse about their use and they confirmed they had been used over a period of several days, despite doom kits only being designed for single use.

The provider showed us an audit trail of medicines ordered. On the ground floor reconciliation sheets were used to track how much of each medicine was in stock but the balance on these did not always match information on the medicine administration record (MAR) or actual stocks of medicines counted. We found eight examples where the stocks of medicine in the home did not match up to what had been ordered and administered. It was not clear if doses had been missed, people had been given more medicines than they should have, or there were consistent recording errors. This was fed back throughout the inspection as an ongoing concern as it would have had a negative impact on people's health and wellbeing if they were getting incorrect doses of their prescribed medicines.

For one person, their medicine for Parkinson's was given at different times on the MAR we looked at. This could have made them feel unwell and put them at higher risk of falling over. For people on PRN medicines (to take as and when required) the service had protocols in place. However these were not always followed as we saw two cases where the medicine was administered and the time of administration and its effect were not recorded.

We observed one instance where best practice was not used to administer a controlled drug. At 12.45pm we saw the two staff members leave the medicine room with a medicine pot containing the prescribed drug.

The staff did not take the MAR chart with them and had signed and witnessed the drug as being administered before the person had actually taken it. This was not in line with the provider's policy which stated "The witness ensures that the staff member gives it to the right resident and witness must observe the resident taking the controlled drug. Administration is then recorded on the Controlled Drug Record and MAR."

Weekly medicines audits had been completed. On numerous occasions the audits documented a request for staff that had missed signatures on the MAR to complete them when they were next available to do so. This was against best practice guidelines from the Nursing and Midwifery Council and the provider's medicines policy. We asked the auditor about this practice and they could not explain why they had done so or acknowledge that it might be a safety issue to go back to MAR charts and change them at a later date. We fed this concern back to the area manager and home manager.

We looked at the records for one person who had needed pain relief towards the end of their life. This person had exhibited signs of pain described in care notes but records around pain relief were poorly kept. The pain relief medicine ran out at one point, leaving them without it for longer than the prescribed dose interval. We also saw that for this person when they had been given medicines through a syringe driver to make them more comfortable, protocols had not been followed and checks had not been made on the efficacy of the syringe driver in line with the instruction on the syringe driver record sheet. This meant the person was not on occasion getting continuous pain relief cover in their final days and equipment was not checked properly to ensure it was working.
During the inspection a person told us that they had sustained bruising on their arm. They showed us the bruises. We fed this concern back to the home manager and area manager. The home manager said the person was susceptible to bruising, they had discussed some bruising on their arms recently and it was due to them knocking themselves on furniture. We asked if there were documents in place to assess this susceptibility to bruising and a body map to support where the bruise was located and how it healed. The home manager said that there was. There were not any documents pertaining to an assessment of bruising, body maps or a discussion about bruising for this person. We asked if these documents could be stored anywhere else and were told they were not in place. This person was being put at risk because there was no assessment of their injuries or a plan in place for how to reduce the risk of them happening again.

The above evidence is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a discrepancy with how medicines were managed between the ground floor and first floor, with all medicines stocks reconciled on the first floor and MAR charts legible and medicines organised. This was not always the case on the ground floor where mistakes had been made and not picked up and systems in place were less organised.
The home could evidence they were returning medication appropriately and had records to evidence this including individual dose destruction records in medicines folders and a central returns book.

We saw safe practice for a person taking Warfarin to thin their blood, they were regularly blood tested and had a dosing schedule for staff to keep to. For people with epilepsy there was a seizure plan in place and stocks of emergency rescue medicine in the home ready for use. For another person who was having a medicine reduced, there was a reduction in dose schedule in place and detailed support plan outlining how this medicine could be reduced safely to minimise ill effects. This was good medicines practice.

Application of creams was recorded and body maps were used. Creams were labelled and with the right person that they were prescribed for. One person who required thickener in their fluids had instructions on

how to do this stored with their MAR chart so that water was given safely during the administration of medicines. We also saw that for homely remedies used these were in date and stocks balanced with those recorded.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection on 10 January 2017 we found the principles of the MCA were not being followed. DoLS were not always being applied for when required and in some cases being applied for when not needed. Consent documents were missing or contained conflicting information for some people. We also found that supervision was not taking place regularly to evidence that staff were being supported to do their jobs effectively.

At this inspection we found some improvements in the area of consent. For example DoLS applications were now being made where needed, followed up for a response, and the tracker where this information was stored was mostly up to date. Some care files we looked at during our previous inspection now had better information around consent. However, we also found there were still inconsistencies and the principles of the MCA were not always being followed.
During the inspection we found mental capacity assessments for three people were not reviewed in line with the MCA or the provider's policy of six months. Where the provider's mental capacity assessment in respect of being able to participate in care planning identified varied or lack of capacity, there were no subsequent best interest decision records except for the use of bed-rails. This was the case for four care files we looked at. Where two people were assessed as having capacity to participate in care decisions, DoLS had incorrectly been applied for. This was an issue we identified at our previous inspection and showed a lack of understanding of when it was appropriate to make an application to deprive a person of their liberty.

For one person the future decisions section of their care plan noted they were unable to make decisions about their future. There was no mention of any involvement by this person in creating this section of the care plan. No mental capacity assessment or corresponding best interests decision documentation were in place.

We found contradictory information for one person in their care plan stating they had capacity to make all decisions around care, but on another section it noted they had variable capacity for decisions about their safety. There were no best interests documents in place around this variable capacity for the placement of bed rails. We fed all of these issues back to the home manager and area manager and they said they will look into them.
At our previous inspection we saw a 'do not attempt resuscitation' form that had not been fully filled out. At this inspection we could not find the form and nurses and staff could not locate it either. This form recorded the decision not to resuscitate this person in the event of a medical emergency. If there was a medical

emergency medical staff would have no confirmation of whether to proceed and resuscitate. We fed back our concern, the home manager confirmed after the inspection the person had been seen by their GP as a result of our concern about the missing form and the decision had bene made by the person they did want to be resuscitated.
The home had not sufficiently addressed the issues raised at the last inspection and so was still in breach in this area.

The above evidence demonstrates a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff supervision and appraisal records showed improvements had been made in this area as the frequency of supervisions had increased. Staff said they felt supported by the new home manager and supervisions were taking place. Records showed that 36 care and nursing staff had had supervision out of 50 for the short time period we looked at. This assured us the home manager was supporting staff so they could do their jobs effectively. We found sufficient improvements had been made and there was no longer a breach of legal requirements in the area of staffing.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 10 January 2017 we had concerns that complaints were not being managed effectively. We also found care files and care were not always person centred. Complaints were not all recorded on the home's complaints log and not always responded to according to the provider's complaints policy. We also found one person's complaints were not recorded or taken seriously by the registered manager who was in post at the time of the previous inspection.

At this inspection we found there had been improvements in how complaints were managed. People told us they were happy with how to make a complaint and they were confident they would be followed up. We looked at complaints records and saw complaints were being recorded and there was a paper trail explaining how each step of the complaint had been responded to. Correspondence written by the home manager met the response times specified by the provider's policy.

We also looked at person centred care and how people's care was individualised. We observed interactions care staff had with people and how their care was presented in care plans and other supporting documents. We asked people if they felt their support was tailored to them as an individual. One person said "No, not really, they try and accommodate it"." but another said "Well I think it is." When we asked family members they said "Yes, I know her care is tailored and very individually to her needs and expectations" and "I think they do their best to give mum the best service." People told us they could choose when they get out of bed and when they go to bed. We observed that one person liked to get up at 10.30 every morning and had breakfast and medicines later than everyone else as this was what they wanted. One person said "I can stay in bed or I can also go to the lounge."

Care files contained some personalised information about people's likes and dislikes. However many care files still did not contain consistent person centred information on how people wanted their care to be delivered. For example some people had generic descriptions of how they wanted to have personal care or no description of how they liked to be supported at night or what they liked to eat. We saw improvements in the consistency of how preferences were recorded around which gender of staff people wanted and how they liked to sleep. On activities logs for one person we saw them taking part in activities that their care plan said they enjoyed doing such as reading the daily newspaper and discussing current affairs. We saw some good examples of person centred descriptions of how care should be delivered and for some people the kind of toiletries they liked to use. We asked the home manager how they were improving person centred care in the home. They said there is "lots of coaching and mentoring going on for a changing culture of staff to ensure not every person gets the same care."

The home manager told us about a 'person of the day' discussion they had introduced so the needs of one person were discussed with care staff and reviewed with the person and relatives if appropriate. The manager said that this way every person in the home would have their needs reviewed with a focus on how they wanted to have care provided.

We found the home was no longer in breach as sufficient improvements had been made in this area.

However, there were still areas for improvement in care files around capturing the person centred nature of care people liked.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 10 January 2017 we found documents were not always up to date, accurate or complete regarding consent, people's daily care and staff supervision. We found the governance systems and processes, to assess and monitor the quality and safety of the service and ensure all relevant information was kept on file for people receiving care, were not effective.

At this inspection improvements had been made to supervision records and daily notes were kept updated. Some improvements had been made to consent documents but there were still inconsistencies. We found a new breach of regulations regarding safe care and treatment involving multiple medicines concerns, and some missing documents to assess and mitigate the risk of bruising to one person. Further to this we found that audits completed by a member of the management team had found gaps in medicines records and told staff to go back and fill them in after the omission had been made. This was potentially putting people at risk and not following best practice guidance from the Nursing and Midwifery Council and the provider.

Audits were completed regularly with some eliciting improvements, but others not having picked up gaps that we found at our previous inspection. Audits took place weekly and monthly for medicines. Care plans were audited regularly by the home manager and deputy manager. The provider sent in managers from other homes to audit, and the area manager worked with the home to improve standards. There was a weekly clinical risk meeting and a home review audit by the provider. Despite this there remained omissions and inconsistencies in some people's documentation relating to consent to care and treatment. Medicines errors and gaps had not been picked up on audits, and those medicines concerns that had been picked up were followed up with actions that were not safe. We also found that there was not a record of risk around bruising of one person that the management team knew about and therefore the risk had not been mitigated. The governance of the home failed to ensure safe care and treatment for people and to act sufficiently upon concerns found in areas relating to consent and completeness of records relating to quality audits.

The above evidence demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Arkley Care Home requires a registered manager to be in post as part of its registration requirements. There was a registered manager in post at the time of the previous inspection but not for this inspection and there had not been one since 27 February 2017. They were still showing as registered in the service but had nothing to do with the running of the service and no longer worked in the home. We prompted the new home manager to submit their application and documents for registration early in June 2017 as they had not yet been registered to manage a service that provided a regulated activity.
Staff said they found the home manager supportive, we saw they had introduced positive changes to the home and wanted to improve the care. They had good knowledge of people's needs and were helpful and responsive throughout the inspection.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to provide safe care and treatment to service users by not assessing and doing all that is reasonably practicable to mitigate risks to people, and failing to ensure the proper and safe management of medicines.

The enforcement action we took:

Warning notice