Bupa Care Homes (CFChomes) Limited

Premier Court Residential and Nursing Home

Inspection report

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Overall summary

We carried out an unannounced comprehensive inspection of Premier Court Nursing Home on 20 January 2015 at which breaches of regulations 9 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were found, which correspond to regulations 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This was because people's care plans did not always accurately reflect their needs and risk assessments were not always in place. Medicines were not always managed safely for people and records had not been completed correctly.

Following the comprehensive inspection, the provider wrote to us on 17 April 2015 to tell us how they would meet the legal requirements. We undertook a focused inspection on the 08 June 2015 to check that they had followed their plan and to confirm that they now met 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 Premier Court Nursing Home on our website at www.cqc.org.uk

Premier Court Residential and Nursing Home provides accommodation for up to 59 older people who require nursing care and may also live with dementia. At the time of our inspection 37 people lived at the home.

The home's registered manager had been in post at Premier Court Nursing Home since October 2014. 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 and associated Regulations about how the service is run.

At our focused inspection on 08 June 2015, we found that the provider had followed their plan which they had told us would be completed by 31 May 2015 and legal requirements had been met.

There were suitable arrangements for the safe storage, management and disposal of people's medicines, including controlled drugs.

People's individual care and support needs had been assessed and documented. There was clear instruction for staff to follow to manage any risks to people's health, safety and wellbeing.

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?

Requires improvement

We found that action had been taken to improve the safety of the service.

People's care plans had been redeveloped to accurately reflect their needs and to provide guidance for staff to manage risks to people's safety and welfare.

People's medicines were managed safely.

This meant that the provider was now meeting legal requirements.

Improvements had been made and we have revised the rating for this key question from 'Inadequate' to 'Requires Improvement'; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for safe at the next comprehensive inspection.

Is the service responsive?

Requires improvement

We found that action had been taken to improve the responsiveness of the service.

People's individual care and support needs had been identified and guidance was available for staff.

This meant that the provider was now meeting legal requirements

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for responsive at the next comprehensive inspection.

Premier Court Residential and 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 was 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 a focused inspection of Premier Court Nursing Home on 08 June 2015. This inspection was completed to check that improvements had been made to meet legal requirements after our comprehensive inspection 20 January 2015. We inspected the service against two of the five questions we ask about services: is the service safe and is the service responsive. This is because the service was not meeting legal requirements in relation to these questions. The inspection was undertaken by one inspector.

Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements and we spoke with the local authority commissioning team.

During the inspection we spoke with three people who used the service, the registered manager, the deputy manager, three members of the nursing staff, two care staff and a member of the senior management team. We reviewed three people's care records, the management and storage of medicines and medication audits.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Premier Court Nursing Home on 20 January 2015 we identified a beach of the regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that people may not always have received consistent and safe support because the risks associated with such areas as moving and handling, diabetes care, and pressure area care had not been assessed and planned for.

At our focused inspection 08 June 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 9 described above.

A new care plan format had been implemented which meant that staff had access to clear written guidance about people's support needs. For example, where a person had been assessed as requiring support to maintain their safety, there were care plans relating to the use of bedrails, nurse call bells, moving and handling and skin care. The care plans were detailed and had related risk assessments. Where people required support to move around the assessment covered all areas such as being supported to turn in bed, to move up and down the bed and to transfer in and out of bed.

Staff told us the new care plans were easy to follow and contained the guidance they needed to support people safely. We viewed a care plan for a person who was unable to move independently. We checked that the actions in the care plan had transferred into practice. We found that the person was positioned as guidance suggested with call bells in reach and bedrails deployed. This meant that the guidance in the care plan had been followed to help keep the person safe.

Where people had been identified as being at high risk of developing pressure ulcers we found that body maps and positional charts had been developed to clearly guide staff to assist people to re-position in order to protect their skin. Where people had been diagnosed with health conditions such as diabetes we found that there were clear instructions for care staff to follow to maintain their health and wellbeing.

At our comprehensive inspection of Premier Court Nursing Home on 20 January 2015 we identified a beach of the regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that people's medicines were not always managed safely and records had not been completed correctly.

At our focused inspection 08 June 2015 we found that the provider had followed their action plan to meet shortfalls in relation to the requirements of Regulation 12 described above.

There were suitable arrangements for the safe storage, management and disposal of people's medicines, including controlled drugs. Staff told us they had received medication training and that there were regular assessments undertaken to ensure their continued competency to administer medicines safely.

People's medicines were stored safely in secure rooms where the temperature was monitored to ensure their safety and efficacy. Staff were able to demonstrate that people who were prescribed medicines on an 'as required' (PRN) basis to manage pain were offered their medicines at the prescribed intervals. Staff had a clear understanding as to how individuals may express pain and therefore benefit from their PRN medicines.

Some people were prescribed medicines as a variable dose to manage their pain, for example, one or two tablets to be taken up to four times a day. We saw that record keeping had improved to indicate how many tablets had been administered for people. This helped to keep an accurate audit trail of the medicines in the home and to contribute to an assessment of how people were having their pain managed.

All people prescribed medicines as PRN or as a variable dose had individual protocols in place to be reviewed every three months. This helped to minimise risk and encouraged the appropriate use of PRN medicines.

At our previous inspection in January 2015 we found a number of examples where recording errors meant that it was not clear if people had received their medicines according to the prescriber's instructions. At this inspection we found that there had been significant improvements in

Requires improvement

Is the service safe?

this area. There were some gaps in recording however these had been identified through weekly management audits and the appropriate actions had been taken to identify and resolve the issues.

Requires improvement

Is the service responsive?

Our findings

At our comprehensive inspection of Premier Court Nursing Home on 20 January 2015 we found that people may not always have received appropriate support because staff had not been provided with adequate information or guidance about the care and support required.

At our focused inspection 08 June 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 9 described above.

People told us they were satisfied with the care and support they received. One person said, “They do it how I want it, there is never any argument.”

A new care plan format had been implemented to make sure that people received care that was centred on them as individuals. We saw that people’s care plans focused on what elements of their care they were able to manage independently and what areas they required support or encouragement with. For example, one person’s care plan clearly identified that they required support from staff to physically access the bathroom but they were able to wash their own face and front of their body. They required support from staff to wash their back and to support them to return to their chair. This meant that the person was given as much choice and control as possible to maintain maximum independence whilst receiving the support they need.

We saw that people’s views formed the basis of care plans with relatives contributing when people did not have the capacity to be directly involved themselves. Care plans were reviewed monthly and any changes to people’s individual care regimes were clearly documented.