Care Quality Commission

Bupa Care Homes (CFHCare) Limited

Perry Locks Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

This focused inspection took place on 10 and 11January 2017. Our last inspection of this service was on 29 and 30 June 2016. At that time we found that although improvements had been made since the previous inspection in June 2015 some further developments were required to ensure that the service was fully compliant with the regulations. Following our inspection in June 2016 we received some concerns about staffing levels at the service and there was also information that raised concern about people's safety.

This report covers our findings in relation to this unannounced focused inspection where we only looked at the domain of 'Safe'. We visited the service at night and returned the next day to complete the inspection. You can read the report from our last comprehensive inspection by
Selecting the 'all reports' link for Perry Locks Nursing Home on our website at www.cqc.org.uk.

Perry Locks Nursing Home is registered to provide accommodation and nursing care for 128 people who have nursing or dementia care needs. There were 118 people living there at the time of our inspection. The home is purpose built and consists of four separate buildings. Perry Well House is for people with dementia. Brooklyn House, Calthorpe House and Lawrence House provide nursing care for older people. The service had a number of intermediate beds across the four houses. Intermediate beds means specialist care to people who have been discharged from hospital but need extra care and support before they return home.

There was a registered manager in post. 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.

People did not always receive care and support in a timely manner and improvements were needed to ensure that there were enough staff to care for people safely at night. Improvements were needed to the management of medicines, to the support people received to eat safely and to ensure that systems in place for ensuring people's safety were well established. You can see what action we asked the provider to take at the back of this report.

People were protected by robust recruitment procedures and staff received training and told us they were aware of their responsibility to protect people from the risk of abuse. Staff told us that they knew what to do to ensure people's safety in the event of a fire and or an emergency.

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

The service was not safe

People were not always supported by enough members of staff to meet their needs. Further improvements were needed to ensure that safe medicine management systems were in place. People did not always receive the support required to ensure safe and consistent practice.

The provider's recruitment systems and processes ensured that staff were
recruited safely.

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

Perry Locks 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 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 inspection took place on 10 and 11 January 2017 and was an unannounced inspection. On the 10 January we visited the service in the evening and spent time on Lawrence House, Perry Well House and briefly visited Brooklyn. On 11 January we spent time on Lawrence and Calthorpe House.

The inspection team comprised of two inspectors.

In planning our inspection, we looked at the information we held about the service. This included the last inspection report and notifications received from the provider about deaths, accidents/ incidents and safeguarding alerts which they are required to send us by law. We had received information that indicated that people may not always be cared for in a safe way and we used this information to inform our inspection. We contacted the local authorities and commissioners that purchase the care on behalf of people, to see what information they held about the service and we used this information to inform our inspection.

We spoke with 10 people who lived at the home and five relatives. Some people were less able to express their views and so we observed the care and support that they received in communal areas. We spoke with eight care staff , three nurses, two unit managers and the registered manager.

We looked at four care records to see how care and treatment was planned and delivered. We also looked at records maintained by the home about staffing, training, health and safety and medicine records.

Requires Improvement

Is the service safe?

Our findings

At a previous inspection in June 2015 we found the arrangements in place for ensuring sufficient staffing arrangements were not effective and did not ensure people's wellbeing and safety. We issued a warning notice. In October 2015 we carried out a focused inspection and found that improvements had been made and the requirements of the notice had been met. At our last inspection in June 2016 we found that the registered manager had continued to build on the improvements to staffing arrangements. This included; having a more stable staffing structure in place, reducing the use of agency nurses, carrying out a skills mix analysis daily so that staffing needs across all four houses' were managed more effectively. In addition a new middle shift had been introduced in Perry Well house in response to people's needs. Most people and relatives at that inspection told us that there were adequate staff available to meet people's needs. The registered manager told us that the provider had developed a new method to determine staffing levels and they would be reviewing staffing levels in accordance with this across the service.

At this inspection observations we made particularly at night showed that people did not always receive the support they required, when they required it. On Lawrence House there were 29 people living there and three of the people had been discharged from acute hospitals for intermediate nursing care. We were told by the unit manager that more than twenty of the people required two members of staff to assist them with their mobility and three people were on hourly checks due to assessed risks to their safety. Some people were also being cared for in bed. One person told us, "The staff are struggling I think they have too much to do". Another person told us, "Some of the staff are very nice and helpful. But I have to wait a long time when I ask for help and then I feel rushed when they do come to help me". A member of staff we spoke with told us, "One nurse and two care staff at night is just not enough. It has an impact on the staff they get very tired and they struggle to get around to everyone". Another staff member told us," We can't deliver care in the way that people want it. Some people like to get up early and we just can't provide the care when they want it. This causes some people to get agitated". A relative told us that they were not happy with the care their family member received at night, they told us, "There is not enough staff to care for people properly". Another two relative's we spoke with whilst praising the staff for how they cared for their family member they also told us that there was not enough staff on duty at night. During the day time on Lawrence House we saw that staff were busy but communicated well with each other about what they were doing. However, people were still being supported with their morning routine up to 12.30 pm and staff told us that this reflected most days. Staff explained to us that some people wanted to get up early in the morning [before the day staff arrived] because this was their preferred routine. However, staff told us that because there was only two care staff working until 8.00 am they were not always able to meet these requests by people. The providers system for monitoring staffing levels had not identified this need.

On Perry Well House we saw that things seemed disorganised. We heard buzzers constantly sounding (these are call systems in people's room so that they can alert staff that they need assistance) people were shouting out and it seemed unclear which staff were responding to the buzzer and who was doing what. We saw in the lounge area that one person drank another person's drink. We were concerned that in doing this it may of presented a risk to the person. Staff were busy supporting people to see that this had happened. One person found this particularly upsetting and started shouting; it was at this point that staff then started

to intervene in a reactive rather than proactive way. On Calthorpe House we spoke with a person and their relative who told us, "It is lovely here, I am very happy but there is not enough staff, especially at night. There is only two of them I feel sorry for them". Another person told us, " On the whole we are well looked after food is lovely but we could do with more staff especially after breakfast I have to wait up to an hour to go to the toilet; it is not good enough". The registered manager told us that due to unexpected staff absence the twilight shift could not be covered at short notice.

We were told by the unit manager on Lawrence House that due to staffing difficulties and a number of staff suspensions they had been unable to provide staff for the twilight shift but hoped that this would be in place from February 2017 as new staff had been recruited. The twilight shift is a staff member working up until midnight to provide additional staff to assist people with their evening and night time routines. All the staff that we spoke with told us that they needed more staff on Lawrence at night and that two care staff was not enough. In addition during the day on Lawrence House staff explained that because a staff skill mix assessment was completed daily to monitor staff across the four houses if another house was short then staff would be moved to provide the cover and this again impacted on the care they provided to people. The registered manager told us this is an agreed and effective way of managing and maintaining adequate staffing levels across the home. The principle applies across all houses and the impact on staffing levels are assessed before any changes are made to ensure staff staffing levels are maintained in accordance with people's care needs.

We found that the systems that had been implemented to ensure that staffing levels were adequate had not always been effective. The provider responded immediately to our findings about staffing levels and told us that they were going to revisit the tool they have in place that assesses the level of care that people need and the staffing level required to meet these needs. Whilst this review was taking place they told us that they would put a third care member of staff on Lawrence House.

At our last inspection we found that some people did not always get their medicines as prescribed. For example we found records were not always clear enough to show how specific medicines should be administered. We found that the administration of eye drops did not ensure safe practice because records about administration of eye drops were not clear. We found that skin patches were not always being used in line with manufacturer's guidance. Practices in place did not ensure creams were being applied as prescribed. Some people needed to have their medicines administered directly into their stomach through a tube. Written protocols were in place to inform staff on how to prepare and administer nutrition but these lacked information around medicines.

At this inspection we focused only on the areas of medicine management that had been identified at our last inspection as requiring improvement. We looked at medicine practice in Lawrence House and Calthorpe House only. We found that improvements had been made to ensure that skin patches were applied in accordance with manufactures guidelines and records showed that body maps were used to ensure the patches were not applied to the same area within a seven day period. We saw that improvements had also been made to protocols in place for people who received their medicines directly into their stomach through a tube. Staff told us that they should record in the daily records the name of the cream and the time it was applied. Although we saw some entries of cream administrations these were not consistently recorded which indicated people were not always receiving their creams as prescribed.

On Perry Well House we saw that a person who had been assessed as requiring a pureed diet due to risks associated with choking was served sandwiches and biscuits for their supper. When we asked staff about this they were unsure about the person's eating requirements. When we checked the person's records their eating requirements had been assessed in November 2016 and a purred diet was introduced at that time.

This was reviewed again in December 2016 with no changes made to the care plan. The food records we checked showed evidence of pureed meals for some but not all meals and also showed that the person had been given sandwiches and biscuits on at least three other occasions. We asked the nurse who checked the records why the issues had gone unnoticed and they told us that food amounts were checked however, these checks did not include the content of what people were eating. On Lawrence House we saw that a person had been assessed as at risk of choking and required a fork mashable diet. The person was able to make choices about their food and staff told us that they had refused to follow the guidelines that had been put in place to keep them safe from the risk of choking. We saw that steps had not been taken to ensure the person was supported in the decision making process in relation to the risks to their own safety. For example, no discussion had been arranged with the person and other people involved in their care to explore how this person could be supported whilst still respecting their right to make food choices.

On Perry Well House we saw that a person's leg was red, looked inflamed and was bleeding. In the handover we observed that no concerns were shared with staff about this person and staff told us that nothing had been passed over by the day nurse to them. When we discussed this with staff they agreed that the leg looked inflamed and told us, "Their leg is bad I will definitely make sure the GP is called tomorrow because [the person] needs antibiotics, they [the person] are not on any at the moment and I am not aware of a GP request". They assured us that this would be followed up with the doctor the next day, which they did and antibiotics were prescribed. The systems in place did not ensure that changes in people's condition were being identified and responded to in a timely manner.

We saw a lifting aid used to assist people move safely was blocking a fire exit and a fire extinguisher on Perry Well House and it remained there for the duration of our visit. This meant that in an event of a fire access to fire fighting equipment was restricted and also the fire exit. A staff member told us on Brooklyn House that the pager they were carrying to alert them of a person requiring help, "Wasn't working properly". This meant that they didn't know which room they should be going to give assistance. On Perry Well House we were also told us that they were having problems with their pagers and faults in the call monitoring system made it difficult for staff to know who and when people required assistance. We asked the registered manager about this and she explained that they required new batteries to be fitted and that spare batteries were available on each of the houses so these could be fitted by staff when required. In a number of bedrooms on Perry Well House we saw that people's call bells were on the wall and not within their reach. Staff advised us that this was because the people were not able to use the call bells. The registered manager told us that the call bell is monitored by the maintenance manager. This includes collecting a print out of the system and completed checks every morning, the print out identifies any call bells in which the battery needs changing. When a battery requires changing it cause the pager to bleep frequently as a warning, however it still identifies individual calls from rooms to alert staff.

We observed on Lawrence House that a handover took place between the day and night nurse and this involved going to each person's bedroom and doing a verbal and visual handover to ensure an effective handover took place. If the person was not in their bedroom we saw that their where abouts was confirmed. On Perry Well House we observed that a handover between day and night staff took place. However, this was completed in the nursing station and did not involve a visual check of people. We observed a member of staff indicated that their shift had finished, put their call monitoring pager down and proceeded to leave the unit before the handover had finished. This meant that two members of the night staff had to leave the handover before it was complete to attend to the needs of the people in the communal area. We saw that another staff member took a personal call on their mobile phone and the handover was also interrupted by an additional telephone call in the office. This meant that the arrangements for the handover of information on Perry Well House did not ensure that the system was robust.

The evidence above support a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment. You can see what action we have taken at the end of the report.

Staff we spoke with knew what action to take to keep people safe from the risk of abuse and avoidable harm. Staff were able to describe the different types of abuse and their role in protecting people. Records showed that staff had received safeguarding training. Staff knew how to escalate concerns about people's safety to the provider and other external agencies. The registered manager was aware of their role and responsibilities in raising and reporting any
Safeguarding concerns and they had a system in place to monitor the progress of investigations in order and to identify and respond to any trends. Some safeguarding matters were in the process of being investigated when we visited.

We saw people were given reassurance when they were supported by staff to move safely using lifting equipment such as hoists. The provider had emergency procedures in place to support people in the event of a fire. Fire safety equipment and other equipment were regularly checked to ensure it was maintained in good working order. Staff we spoke with confirmed they had received fire safety training and were able to talk us through what they would do if the fire alarm activated and the action they would take to keep people safe.

We saw that robust recruitment procedures were in place to ensure that only staff that were suitable were employed.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment **Care and treatment was not always provided in a safe way for people**