Bupa Care Homes (ANS) Limited

Bakers Court Care Home

Inspection report

138-140 Little Ilford Lane
Manor Park
London
E12 5PJ

Date of inspection visit:
11 August 2016
12 August 2016
18 August 2016
19 August 2016
22 August 2016

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29 November 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Bakers Court is a residential and nursing home which provides nursing and personal care for up to 78 people. The home is spread over three floors. At the time of this inspection there were 72 people using the service. There were 31 people using the ground floor which was dedicated to people who needed nursing or residential care. The middle floor was for people who had mental health needs and there were 20 people using this service. There were 21 people using the top floor dedicated to people living with dementia. At the last inspection on 15 July 2014 the service was found to be meeting the legal requirements.

The manager in post at the time of our inspection was in the process of becoming registered. 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.

Staff knew how to report concerns or abuse. There were enough staff on duty to meet people's needs who were employed through safe recruitment processes. Risk assessments were carried out and management plans put in place to enable people to receive safe care. There were effective and up to date systems to check and maintain the safety of the premises. We found errors in the management of medicines however the provider had already identified this as an area of concern and had taken steps to improve this. Records showed that improvements had been achieved as a result of the provider's actions.

Staff received support through supervisions and training opportunities. Appropriate applications for Deprivation of Liberty Safeguards had been applied for and authorised. The service was working jointly with the local authority to get the authorisation of other applications. Staff obtained consent when carrying out care or treatment. People were offered a varied and nutritious food menu and had access to healthcare professionals as required to meet their day-to-day health needs.

People thought staff were caring and staff knew how to build positive relationships with people who used the service. Staff ensured people's privacy and dignity was respected and their level of independence was maintained. Each person had a named nurse and named carer who they could speak with as a first point of contact.

Staff knew the people they were supporting including their preferences to ensure a personalised service was provided. A variety of activities were offered which included trips outside the home. The service dealt with complaints in accordance with their policy and timescales.

People and staff thought the new manager was approachable and supportive. The provider held regular meetings for staff and for people and their relatives. People and their representatives were given the opportunity to complete feedback surveys. We have made a recommendation about communicating the results of these surveys to interested parties. The provider had quality assurance systems in place to identify

areas for improvement and had brought in extra support to enable improvements to take place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were enough staff working to ensure people were kept safe and the provider had carried out relevant recruitment checks for new staff. Criminal record checks were up to date.

Staff were knowledgeable about raising safeguarding concerns and whistleblowing. People had risk assessments in place to ensure risks were minimised and managed. The provider carried out the necessary building safety checks to ensure people, staff and visitors were safe on the premises.

We found several medicines errors during our visit. However the provider had already identified there were concerns over management of medicines and had introduced new systems to ensure this improved. Additionally nursing staff were receiving extra support and training to help them improve in this area.

Is the service effective?

Good

The service was effective because staff received support through regular training opportunities and supervisions to enable them to give care effectively.

The provider was knowledgeable about what was required of them to work within the legal framework of the Mental Capacity Act (2005) and staff were knowledgeable about when they needed to obtain consent from people.

People were offered a choice of nutritious food and drink. Staff were knowledgeable about people's dietary requirements. People had access to support from healthcare professionals as required.

Is the service caring?

Good

The service was caring. People told us staff were caring. Staff knew how to develop positive relationships with people using the service and were knowledgeable about their different needs.

Each person had a named nurse and carer who oversaw their care and was their point of contact within the service.

Staff were knowledgeable about promoting people's privacy and dignity and about encouraging people to maintain their independence.

Is the service responsive?

Good

The service was responsive because staff were knowledgeable about people's individual needs and preferences. People's care plans were detailed and personalised and were regularly reviewed. Staff were knowledgeable about people's care plans and about giving personalised care.

There were a variety of activities on offer for people including visiting entertainers and trips into the community. People and their representatives knew how to make a complaint and complaints were dealt with in line with the provider's policy.

Is the service well-led?

Good

The service was well led. There was a home manager who was in the process of becoming registered with the Care Quality Commission. People and staff were complimentary about the leadership of the service.

Regular meetings were held with staff to keep them updated on service development and for the home manager to be updated on the well-being of people who used the service. People who used the service and their relatives had regular meetings to enable them to raise issues of concern and to keep them updated on changes.

The provider had a system to obtain feedback from relatives and professionals visiting the service, however this information was not readily available. We have made a recommendation about this.

The service was working to an improvement plan because of areas of concern identified by the local authority. There were systems in place to carry out quality checks of the service which were done by the manager and the provider. These systems had been increased and refined to enable the improvements in quality to be implemented.

Bakers Court 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.

We carried out this unannounced inspection on 11, 12, 18, 19 and 22 August 2016. Two inspectors and an expert-by-experience carried out this inspection on the first day. One inspector visited on the other inspection days.

Before the inspection, we looked at the evidence we already held about the service. This included the last inspection report and notifications the provider had sent us. 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 spoke to the senior contracts officer at the local authority to find out if they were happy with the service provided to people or if they had any concerns.

During the inspection, we spoke with thirteen staff including the regional support manager, the home manager, the deputy manager, three nursing staff, three care staff, the cook, the activities co-ordinator, one of the housekeeping team and the maintenance person.
We also spoke with three visitors and eight people who used the service. We observed care and support in communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We reviewed six care records, six staff files and records relating to the management of the service including menus, medicines, staff training, complaints and policies.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "I do feel safe; they handle me with care. They are very careful when they get you in and out of bed and always ask you if you are comfortable." People thought there was enough staff on duty to meet their needs. However one visitor told us, "There's not enough staff here, they come and go." Six staff told us sometimes there were not enough staff at busy times when staff phoned in sick.

We discussed the staff ratios with the home manager and regional support manager and checked the staff rotas. Records showed there were enough nurses and carers on each floor to meet people's needs. The regional support manager said when there was staff sickness, the deputy manager and the home manager worked on the floor until replacement staff could come in. We also observed the activities and housekeeping staff helped out during meal times. During the course of our inspection, nobody was left waiting for assistance for too long and call bells were answered promptly.

The service had a recruitment and selection policy. There was a process in place for recruiting staff that ensured relevant checks were carried out before someone was employed. For example, staff had produced proof of identification, confirmation of their legal entitlement to work in the UK and had been given written references. Staff had criminal record checks carried out to confirm they were suitable to work with people and these were up to date. Staff were also required to complete a health questionnaire to check they were fit to carry out their role. The service had a system in place to check nursing staff were registered with the Nursing & Midwifery Council (NMC) and their registration remained up to date. The NMC is the regulator for nursing and midwifery professions in the UK who ensure nurses and midwives keep their skills and knowledge up to date and that they maintain professional standards. This meant a safe recruitment procedure was in place.

Staff were knowledgeable about how to recognise and report concerns of abuse and about whistleblowing. For example, a staff member told us, "Whistleblowing is passing information of concern about the care or abuse of the person. Confidentially you can go to social services safeguarding, manager or the police." Another staff member demonstrated they had direct experience of whistleblowing in the past by describing two incidents of abuse where they had raised concerns with management. This staff member confirmed they knew which other agencies they could contact. A third staff member told us, "Report it [safeguarding concern] straight away to my line manager, social worker, CQC or the police."

People had risk assessments as part of their care plans regarding their care and support needs. Risk assessments included clear actions for staff to mitigate the risks. For example, people had risk assessments for moving and handling, mobility and falls, skin integrity and bedrails. For example, one care plan noted that two staff were to assist the person with transfers using a sliding sheet and bedrails were to be used to reduce the risk of falling.

We saw building safety checks had been carried out in accordance with building safety requirements with no issues identified. For example, testing of portable electrical appliances was done on 27 July 2016, a gas

safety check was carried out on 11 April 2016 and the emergency lights were checked on 2 August 2016. The provider had a system of regular unannounced fire drills and weekly fire detector and call points which were up to date. This meant the provider had systems in place to ensure the safety of people in the premises.

We checked the medicine administration records for people using the service on the top floor. Four people were prescribed Adcal-D3 tablets and for two people this had been administered correctly. However for one person they had one tablet missing from their box and the other person had one too many. The medicines administration record (MAR) chart showed that the medicines had been given as prescribed to all four people. This showed that staff had not checked the label on the box before administering this tablet. We also found an extra box of Adcal-D3 tablets with no label which meant staff would not know who the tablets should be given to. We checked the medicine administration for people using the service on the middle floor and found the records were completed correctly and the stock of medicines was correct.

We found three errors in medicine administration on the ground floor. For example, one person's teatime blister pack of Memantine was still full but there was no MAR chart in place. The nurse in charge told us and records showed this tablet had been discontinued. However the blister pack should have been removed for returning to the pharmacy in order to prevent confusion.

We raised the issues around medicines with the home manager and regional support manager. They told us that they were aware of concerns around the management of medicines and this was included in the service improvement plan as an area that needed to be improved. All nurses were to have a medicines refresher training and reassessment of their medicine competency. The regional support manager told us this training was in process but not yet completed and the nurses did daily and weekly audits of the medicines. Records showed that issues with medicines were identified quickly through these audits which meant they were dealt with promptly. The deputy manager also did a monthly medicine audit and the regional support manager told us there was a plan for the deputy manager to initially work closely with the nurses on the ground floor as this was where the most errors occurred in order to improve the accuracy in medicine administration.

The provider had introduced a unit manager post on each of the floors to help improve on the quality of care and nursing provided. The provider's recovery team had also brought in extra support from the practice development manager from 16 June 2016, who included medicines checks during their visits. Records of these visits showed the practice development manager spent time training carers and staff to help them to make improvements in the quality of care provided and record keeping. Records showed that the number of medicine errors had drastically reduced since the above measures were introduced.

The provider had a medicines policy which gave clear guidance to staff about the storage and administration of medicines including controlled drugs and monitoring people who self-administer their medicines. There were guidelines in place for people who required "pro re nata" (PRN) medicines. PRN medicines are those used as and when needed for specific situations. We saw PRN medicines had been administered and signed for as prescribed. Medicines were stored appropriately in locked trolleys which were kept in a treatment room.

Good

Is the service effective?

Our findings

Staff told us there had recently been several changes in management which they found unsettling and this meant they had not always felt supported. Staff confirmed they were given regular supervision sessions. The provider's supervision policy stated staff below management level employed in the home should have a minimum of four meetings a year with their line manager to include one annual appraisal, two group supervisions and a one to one meeting. Records showed this was the case. For example, a group supervision held on 26 May 2016 included discussions around prompt answering of call bells and training. One to one supervision discussions included communication, dementia and activities.

Staff confirmed and records showed that they had regular opportunities for training. For example, we saw that staff were required to complete core training such as fire safety, food hygiene, nutrition and hydration and moving and handling. The staff training matrix was colour coded and dated to enable managers to see when staff were due refresher training. We saw staff had received appropriate induction training when they began employment at the service. Nursing staff had a competency assessment before administering medicines without supervision.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of inspection, eleven people had DoLS authorisations in place and the service was awaiting the outcome of 33 further applications. These applications had been made because the individuals needed a level of supervision that may amount to their deprivation of liberty. For example, the provider used a key code lock to keep people safe. The provider had notified the Care Quality Commission (CQC) of these DoLS authorisations as required by the terms of their registration. The home manager was working jointly with the local authority to ensure people were being deprived of their liberty in their best interest and in the least restrictive way possible. For example, two people who used the service and who had capacity were given the number for the key code lock so they could access the community independently.

Staff were aware of the principles of MCA and the need to obtain consent before giving care. A staff member told us, "I ask them [people who used the service], those that can sign their consent will sign and those who cannot sign, we write verbal consent given and the date. Those without capacity we make the decision with the family in their best interests." Another staff member said, "We get consent when carrying out our tasks

throughout the day. If consent is not given, we go away and come back later on. Sometimes you have to go back several times."

People had mixed views about meals at the service. Some people who used the service told us they liked the food and the choices offered. For example, one person told us they were vegetarian and apart from milk, did not consume any dairy products. This person told us they were very satisfied with the variety of food choices. Another person told us they liked the food, "And I can choose what I like." A third person said, "I choose my meals and they bring them in to me. I prefer to eat by myself." However one person had a different view and said, "The chef's got no imagination." The cook had a discussion with this person during lunch to find out what they did not like about the food.

During the inspection we observed lunch being served and saw the food was generous in portion size. We observed a nurse being discreetly attentive to a person who used the service who kept pushing their plate of food away. Their food was cut up and they were able to feed themselves. The nurse gave occasional encouragement to the person to eat without being too insistent. This method was effective as it ensured that the person who used the service was actually having something to eat but also left to make their own choice about this. Some people needed support with their meals. There were enough staff available to ensure that people could have assistance where required. The manager monitored the quality of the meals and sampled the food before serving commenced.

On the first inspection day we noted that people on one floor were not offered condiments with their lunch. We raised this with the home manager and the regional support manager who said they would speak to the cook in order to resolve this issue. This was corrected for the other days we visited.

Staff knew what each person who used the service liked to eat but still asked and offered everyone a choice. Along with a choice of dishes, people were offered a choice of drinks. A member of staff gently reminded one person to stay awake in order to eat their lunch. The cook came up personally to see if the residents enjoyed their lunch and if they were satisfied.

The service used a rolling four week menu which was varied and nutritious. The cook told us each person made their choices in advance but were able to change their mind on the day if they wished. Photographs of meals were available to help people choose. The cook was knowledgeable about people's individual dietary requirement, such as who required soft food, no added sugar, halal or vegetarian meals.

People were weighed monthly to ensure weight loss or weight gain was monitored and those who were at risk of malnutrition had their weight checked on a weekly basis. Food and fluid charts were completed for people who used the service to monitor the food and fluid intake. These records were up to date. Each person had a monthly nutrition review which included their monthly weight and the type of weighing equipment to be used. People could choose to have a small fridge in their room so they could have their choice of cold drinks at any time.

People told us and records confirmed that people were able to access support from healthcare professionals when needed. For example, we saw records of visits from the GP, chiropodist and wheelchair service with the action taken and the outcome. People's health was also discussed at the daily meeting held between the home manager, deputy manager and unit lead staff.

Good

Is the service caring?

Our findings

People who used the service and their visitors told us they thought staff were caring. For example, one person told us, "The staff are lovely; nothing is too much bother for them. Nine out of ten times they do their best." Another person told us, "I couldn't fault them, I'm mostly self-caring but the staff are very good. They [staff] always check in and are very attentive". A third person told us, "They [staff] are very good people, always loving and kind." This person also told us they considered the staff were their family and, "Everybody's happy here." We observed lively, caring and respectful interactions between staff and people using the service. For example, staff quickly adjusted the positioning of one person using a wheelchair who was uncomfortable sitting at the table and this person then said they were okay.

A person who used the service had a number of religious items in their room and told us they could see their church representative when they wanted to. This person told us, "The people are wonderful and they care, they really care. I wouldn't have got as much care at home as I do here."

The provider had a keyworker system in place where each person using the service had a named nurse and a named carer. A keyworker is a staff member who is responsible for overseeing the care a person received and liaising with other professionals or representatives involved in a person's life.

Staff told us how they got to know people and their care needs. Comments included, "Get to know [person using the service] by talking to the person, what they like and what they want to do", "I'm very friendly with everyone, I greet them, you can ask them, I like a bit of banter, the family will let you know", "Chatting and talking to them. Read the care plan. Build up trust and they start to tell you about their life. Talk to the family", This meant staff were knowledgeable about how to build positive relationships with people.

The provider had a system in place to carry out monthly end of life care audits on each floor which included the date of admission and whether each person had a do not resuscitate form in their care plan. Records showed what people's end of life wishes were, for example, whether they wished to remain in the home or be in hospital to receive end of life care.

During the inspection we saw people were treated with respect and in a kind and caring way. One staff member interacting with people said, "I missed my family [people who used the service]", referring to her holiday and she showed them her holiday photographs. People who used the service were heard laughing during conversations with staff.

The provider had a privacy notice which explained to people who used the service how their personal information would be kept securely and confidentially. One person told us "I'm treated better here than I was in hospital. I have enough privacy and that's the way I want it". We observed that staff knocked on people's doors before entering.

Staff were knowledgeable about how to provide people with privacy and dignity. One staff member told us,

"Knock on the door and ask permission to go in. When talking to [person who used the service], talk to them in private, don't shout it out." Another staff member said, "Always knock on the door. Speak to [person who used the service] in a nice respectable tone. Get down to their level when talking to them." A third staff member told us, "You shut the door, the curtains should be drawn. Make sure [person who used the service] are well dressed before you leave their room." This meant people's privacy and dignity was respected.

One person who used a wheelchair and needed support with personal care and bathing said "[Staff] only help me with things I can't do for myself." Staff described how they encouraged people to maintain their levels of independence. Comments included, "I give them the wipes to wipe themselves rather than do it for them. I always tell the other carers to let [person who used the service] feed himself because he's quite capable", "By giving them the option to try themselves", and, "We are not here to disable them [people who used the service]. Anything they can do themselves, we encourage, prompting them to do it." People who used the service had different coloured front doors on corridors with street names to help them to find their room independently. This meant people were enabled to stay as independent as they could for as long as possible.

Good

Is the service responsive?

Our findings

Staff knew what personalised care was. Comments included, "We ask them when and how they would like to be cared for. It has to be their choice", "Personalised care is knowing the person's likes, dislikes and preferences", "I don't group all the residents together. It's whatever they like. One person likes to talk so I make the time to sit and talk [with person who used the service]".

Care plans were comprehensive and personalised with the person's basic details, personal histories and choices and decisions over care. Each person had an assessment of their needs before they began to use the service. Records included people's individual preferences of food, drink, activities, time to get up and time to go to bed. Care plans included people's care needs such as their health, communication, personal care and cultural or religious needs. Care plans were reviewed every month and these were up to date. The manager confirmed that if a person's care needs changed their care plan was reviewed sooner and records showed this was the case..

People using the service took part in activities of their choice. A person who used the service told us, "They buy me a paper every day." Another person described the activities coordinator as being, "The best thing about this place." The activities coordinator showed us the weekly activities programme which included a sewing club, bingo, hairdressing in the on-site salon, massage therapy, sports on the big screen in one of the lounges on each floor and a weekly church service. The activities coordinator also told us a representative from another church also visited each week to offer people holy communion and records confirmed this was the case. Day trips were also organised to the park and to the shops. Entertainers visited to put on performances on each floor.

Individual and group activities were taking place throughout the inspection. One resident told us their favourite activities were arts and crafts. The room used for this purpose was well-equipped with various arts and crafts materials and examples of people's art work. Staff interacted individually with people playing games, doing exercises, and having conversations. One person told us that they chose to participate in three activities but their favourite one was exercises but they also liked having their hair and nails done. This person said, "These girls [staff] are wonderful and I've made friends here". One staff member told us they were planning a tactile activity to involve people with making the unit name on the top floor out of buttons.

People said they knew how to make a complaint but that they had, "Nothing to complain about". One person also said, "Everyday they ask you if you have any complaints." The provider had a clear complaints policy. We reviewed the complaints records and saw six complaints were made between 6 June and 3 August 2016. These complaints had been dealt with in accordance with the provider's policy with the outcome recorded. For example, one complainant was not satisfied with the outcome so this was escalated to the next stage of the complaints process and the regional support manager was in the process of reviewing the outcome.

Good

Is the service well-led?

Our findings

The service had a manager who was in the process of becoming registered with the Care Quality Commission. People told us they liked the new manager and that she had asked them what they liked and disliked about the home. One person who was staying at the home temporarily said, "The manager came to visit me when I first came here."

Staff spoke positively about the new manager. Comments included, "The manager is more determined and tries to keep us focussed. Has also sent us for training", "Our new manager, she's really good. I know she'll be a good leader" and "She [the manager] seems on the ball. Her door is always open. She's approachable and she takes on board what you say".

There was a general consensus from various conversations with people who used the service that they were asked every day for their feedback. Two people recalled that they had completed a feedback survey about a year ago. The regional support manager told us a recent survey had been done with people who used the service and their relatives. However we were unable to see how information gathered from feedback surveys was used as a mechanism to improve the quality of the service. We asked if the analysis of surveys could be sent to CQC after the inspection but at the time of writing this report this had not been received. We recommend the provider reviews how it obtains and records feedback and communicates the results to relevant parties.

The provider held regular meetings for people who used the service. Records of two meetings held on 5 May 2016 and 29 June 2016 included discussions about the choice of food on the menu. The cook asked people what food they would like. The outcome of this was a new alternative menu displayed on the noticeboard on each floor. Another item of discussion was about beds not being made well. The recorded outcome of this was staff were monitored to ensure beds were made properly. Information was given to people at this meeting about a planned refurbishment which was to include the garden area. Records showed people were happy about these plans. The refurbishment work was being completed during the inspection period which included new flooring being laid and new beds being purchased.

Relative's meetings were held quarterly. Records of the meeting held on 14 December 2015. Topics discussed included activities, staff, keyworkers and laundry. Relatives gave positive feedback on the arrangement of entertainers performing on each floor. The most recent relatives meeting on 9 May 2016 was attended by only two families so the home manager met with them individually. Records showed one family thanked the service for the care given to their relative and suggested a guest room be made available for visitors who travel long distance. We saw this suggestion had been taken on board as an unoccupied room was used by one relative during a visit.

The provider had various meetings with staff. Records showed daily 'Take 10' meetings were held which were attended by the home manager, deputy manager and the lead nurse from each floor. These meetings were a forum to update everyone on the well-being of people using the service and activities and events occurring on the day. Each floor had a monthly staff meeting and there was a quarterly general staff

meeting. Records showed discussions included quality of care, health and safety, whistleblowing, changes within the home and staff morale.

The local authority had concerns about the service being provided following their contract monitoring visit on 11 February 2016. As a result the home manager was required to develop and action a service improvement plan. In response to this the provider had asked their recovery team to provide support to the service. This involved the recovery team regional director visiting at least every two weeks and the recovery team regional support manager visiting twice a week. The regional support manager line managed the home manager and carried out random quality checks. Both the regional director and the regional support manager also carried out monthly home reviews. The system of monthly home reviews included first impressions of the home, staffing, general observation of units, and medicines management.

Records of the review on 26 July 2016 showed where areas for improvement were identified with actions to be taken. The home manager signed and dated each action when completed and at the end of the form when all actions were done. For example, one action was for staff dependency reviews to be started to ensure there was enough staff on duty to meet people's needs. This action was signed and dated as completed on 10 August 2016.

The home manager carried out a daily walk around at random times of the day and always after the daily 'Take 10' meeting had been held. The home manager recorded their findings from the walk around on the back page of the 'Take 10' meeting notes. Records of the daily walk around included checks on what time the medicines were administered, the choices available on the food trolley and whether it was brought on time and the level of cleanliness on each floor.