Bupa Care Homes (CFHCare) Limited

Perry locks Nursing Home

Inspection report

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Ratings

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

Overall summary

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, and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This inspection was unannounced.

In February 2014, our inspection identified breached regulations relating to staffing, medicine management and the care of people with dementia. Following the inspection the provider sent us an action plan to tell us the improvements they were going to make. We found that some improvements had been made to the care of people with dementia and medicine management. However there remained breaches relating to safe staffing, and we found additional breaches of regulations in relation to Supporting workers and Assessing and monitoring the quality of service provision.

The home did not have a registered manager in post when we inspected. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has legal responsibility for meeting the requirements of the law: as does the provider.

Perry Locks Nursing Home is registered to provide accommodation and nursing care for 128 people who

Summary of findings

have nursing or dementia care needs. There were 112 people living at the home when we visited. The home is purpose built and consists of four separate buildings. Perry Well House is for people with dementia. Some of the beds on Brooklyn House are intermediate beds (This means short term specialist care to people who have been discharged from hospital but need extra support before they return home). Calthorpe House and Lawrence House each have 30 beds, for nursing care for older people.

Most people that we spoke with told us that they received good care from staff and they were happy with the staff that cared for them. People described staff as kind, helpful and caring. Some people and their relatives told us that there was not always enough staff on duty to care for them especially at busy times of the day, for example, meal times and early evening. Our observations during the inspection supported this. The provider did not have an effective system in place to determine the level of staff needed, to promote people's safety.

Staff had not followed the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). We saw that some people had restrictions in place but an application had not been made to the local authority. This meant that some people were potentially unlawfully having their movements restricted.

Staff knew about people's needs. However some of their training needed updating including fire safety, safeguarding and moving people so that they maintained the level of knowledge needed to care for people safely. Training was needed in MCA and DoLS so staff understood their responsibility in relation to this legislation. Nurses told us that they needed training specific to their role so they had the skills they needed to carry out their clinical duties effectively.

People had access to health care professionals such as doctors and dieticians so that they received the healthcare support needed.

People and their representatives had not always been provided with opportunities to attend regular meetings to express their views about the home. People told us that they knew how to make a complaint and we saw this information was displayed in the home. Some people told us that they had not been satisfied with how their complaint had been dealt with.

The home had not been well led. There were systems in place for monitoring the service however, these had not been effectively applied to identify where the improvements were needed.

We found the provider had breached the regulations related to staffing levels, DoLS, support for staff, and monitoring of the service. The service lacked effective leadership. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Safeguarding procedures were in place and staff knew about their responsibility to reduce the risk of harm.

Some people told us that there was not always enough staff available to provide care and support. The provider did not have a robust system to determine safe staffing levels.

There were systems in place that should make sure that people were not deprived of their liberty. Deprivations of people's liberty had not been identified and managed.

Improvements had been made in the way that medicines were managed so that people received their medicines safely.

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

People did not always receive care that was consistently effective.

People told us that staff cared for them and that they received the health care support they needed. Risk associated with inadequate food and drink were managed, although some people who needed help to eat experienced delays with receiving their meals.

Staff had not received all the training and support they needed to carry out their role effectively.

Is the service caring?
The service was caring.

People spoke highly of the staff and we saw that staff were caring and compassionate in their role.

People told us that staff had respected their privacy and dignity. We saw this demonstrated by staff during our visit.

Relatives told us that staff were kind and caring and that they were made to feel welcome when visiting the home.

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

People told us that they engaged in some meaningful and stimulating hobbies and interests. However we saw that this was not always consistently applied across all four houses.

People told us that they knew how to make a complaint. However, some people told us that their complaints had not always been well managed.

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

The registered manager had left and previous management arrangements prior to the inspection had resulted in the home not being managed effectively.

Monitoring of the service had not been effective and timely in identifying where improvements were needed.

Summary of findings

Regular meetings with people, their representatives and staff where they could raise their views about the home had not taken place.

Perry locks Nursing Home

Detailed findings

Background to this inspection

'This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

'The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.'

The inspection took place on 16 and 17 July 2014 and was unannounced.

The inspection was undertaken by three inspectors, a manager, a pharmacist inspector 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 service. Our expert had particular experience of caring for people with dementia.

Before the inspection, we asked the provider to complete 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 received the PIR within the required timescale and used the information from this to inform our inspection process.

We spoke with inspectors who carried out our previous inspection and we checked the information we held about the service and the provider. This included notification's received from the provider about deaths, accidents and safeguarding alerts. A notification is information about important events which the provider is required to send us by law. We had also received some whistle blowing concerns and people had also shared their views about the service with us through the CQC website.

Before our inspection we also requested information about the service from Birmingham Local Authority and Sandwell and West Birmingham Clinical Commissioning Group. Both have responsibility for funding people who used the service and monitoring its quality.

During the visit we spoke with 20 people who used the service, 12 relatives, ten staff, the acting manager and the provider representative. We observed how people were supported during their lunch and during individual tasks and activities. We carried out a Short Observational Framework for inspection (SOFI) to observe staff interactions with people. We looked at six people's care records to see if their records were accurate and up to date. We looked at four staff recruitment files and records relating to the management of the service including quality audits.

Is the service safe?

Our findings

All of the people we spoke with told us that they felt safe in the home. One person told us, "I feel safe there is nothing that makes me feel unsafe". A relative told us, "I don't worry at night anymore because I know they are safe and the staff do their very best". However, most people, relatives and staff across all the four houses told us that they felt there should be more staff working particularly at peak times of the day. One person who used the service told us, "Sometimes there are not enough staff and I am asked to wait for things such as going to the toilet, but when the staff come to help me they are good". A relative said, "They are great staff but there is just not enough of them". A staff member told us, "We are just rushed off our feet".

In Perry Well House we saw that staff were very busy caring for people in the main lounge area and also attending to a number of people who were being cared for in bed. We noticed a change in atmosphere from calm and relaxed in the morning to more hurried as mid-morning approached. We saw that people became more anxious and unsettled as the day went on. Staff told us that most of the people being cared for in bed were not able to use the call bell to ask for assistance so staff needed to make sure that regular checks were made on people to ensure that they were safe. We observed a person stand up and attempt to walk. The activity staff member stopped the activity to support them as there was no other staff were available in the lounge, at that time to attend to them. We needed to alert a member of staff to attend to a person who had fallen asleep with food in their mouth, in their bedroom so they could prevent a risk of choking. A staff member told us, "You are rushing around all the time you do not feel you are providing good enough care".

In Calthorpe House we saw that people waited at the dining room table for up to 50 minutes before staff were free to serve them and support them with their meal. Staff told us in some of the other houses that when occupancy levels dropped then nursing cover had also been reduced and this had impacted on the care that they could provide to people. A nurse told us, "We need to do certain jobs at specific times such as administering medication, however things just stack up and it is a struggle to get things done". We observed that nursing staff faced a number of interruptions whilst trying to administer medicines to people. These constant interruptions were effecting the concentration of this nurse and could lead to people being given the wrong medicines.

We asked the person in charge what systems they used to ensure there was enough staff to meet people's needs. They told us that the system used had been based on numbers of people in the separate houses and not their support needs. This meant when occupancy levels dropped then staffing levels were reduced. The system had not incorporated the needs of people that used the service to determine the dependency level of people so staffing levels could be based on people's needs. The arrangements in place to ensure staffing levels were provided to protect people from risk and ensure that people's needs were met at the right time and in the right way were not adequate. This was a breach in Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. The provider told us that no one living at the home had their rights, liberty and choice restricted in any way by their care plans. We were told at the start of our inspection by care and nursing staff that no one living at the home was subject to a DoLS safeguard, to protect their liberty. We saw that some people were closely supervised by staff at all times and some people had restrictions in place such as bed sides. The manager told us that they were aware that applications for specific people needed to be made but were waiting on the local authority to lead on this. We discussed with the provider that there was a need for them to fulfil their responsibility and they took immediate action during our visit by making applications to the local authority. This was a breach in regulation 11 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider had failed to ensure that an effective system was in place to prevent people being unnecessarily deprived of their liberty.

We saw that equipment, for example, pressure relieving cushions and mattresses were in use to prevent sores and to promote healing. We saw that people's position in bed

Is the service safe?

was changed to ensure the risk of developing sore skin was minimised. Some people had bed rails in place and we saw that some people had their bed in a lowered position and a mat placed at the side in case they had a fall. Staff were knowledgeable about people's needs and told us how they managed risks to people. We saw that care records highlighted people's risks and how they should be managed. This showed that people's risks had been considered and solutions explored to help minimise any untoward events and to promote their good health.

We saw that one person who was living with dementia was showing signs of unrest and distress when their relative was visiting. We saw that staff were unsure about what to do and how to reassure the person and the situation escalated. We were told later by the unit manager how the situation should have been managed. Two staff that we spoke with were not aware of what to do and care records we looked at did not inform staff of how to manage this consistently. However, we did see other incidents when people had become agitated or distressed and staff generally dealt with these situations safely and as recorded in people's care records.

All the staff we spoke with were able to tell us how they would respond to any incident of abuse and knew the lines for reporting any concerns within the organisation and externally, if they felt that appropriate actions were not taken. Most staff that we spoke told us that they had received training in the safeguarding of adults. However, training records sampled showed more than half the staff team needed this training to be updated. This would ensure that staff's knowledge remained current.

There had been a number of safeguarding alerts raised by CQC with the local authority in April and May 2014 following information shared with us by relatives and from anonymous concerns. The concerns had been investigated by the local authority and commissioners and were in relation to unexplained injuries and concerns about poor care. Investigations by the local authority identified concerns around staffing levels. The Clinical Commissioning Group (CCG) identified that a number of quality improvements were needed, so that people's health and welfare needs were met.

We saw staff supporting people to make some everyday choices. People were offered choices of drinks, where they wanted to sit, if they wanted to join an activity. Most of the staff we spoke with were able to describe how they supported people to make decisions about their care. However this was not always demonstrated in the care records we looked at.

We visited Perrywell and Brooklyn house to look at what arrangements the service had in place for the recording, safe keeping, safe administration and disposal of medicines. We looked at 12 medicine administration records and found that people were receiving their medicines as prescribed by their doctor.

We looked at the disposal records for medicines that were no longer required by the service. The records showed that these unwanted medicines were being disposed of safely.

We found that where people had to have their medication administered by disguising them in food or drink the service had the necessary safeguards in place to ensure that these medicines were administered safely.

Medicines were being stored securely, and at the correct temperatures, for the protection of people that used the service. Medicines requiring cool storage were being stored at the correct temperature and so would be effective.

We found that the information available for the administration of when required medicines needed some further development. We discussed this during our inspection with senior staff so that robust and consistent information would be available for staff to follow.

Is the service effective?

Our findings

We found that staff had not always received the training and support they needed to be effective in their role. Staff we spoke with were knowledgeable about people's needs. However, some staff told us that they were overdue training in specific areas to keep their knowledge and skills updated. We sampled staff training records and saw that training updates were overdue in a number of areas including fire safety, moving and handling and safeguarding, for more than half the staff team. When we spoke with staff about their understanding of DoLS, most staff were unaware of the implications of a recent Supreme Court judgement which strengthens the definition of DoLS.

Three nurses told us that they needed training specific to their role so they had the skills they needed to carry out their clinical duties effectively. Nurses told us that there were no training plans in place for them to complete clinical training. For example, in tissue viability and catheter care to ensure that their clinical knowledge was updated and to ensure they remained competent in their role.

A number of staff told us that there was no regular supervision or appraisal of staff taking place. Supervision schedules we looked at supported what staff told us and showed the frequency of staff supervision and appraisal varied across the four houses and did not meet the provider's policy of supervising staff bi- monthly. This meant that systems in place to ensure people received care from staff who have the knowledge and skills needed had not always been effective. This was a breach in Regulation 23 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010. The registered person had not taken proper steps to ensure that staff were appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to people safely.

We observed meal times in Perrywell, Catlthorpe and Lawrence. We saw that staff were busy during this time and a number of people needed a lot of support to eat safely and effectively. Most people were positive about the choice and quality of food. One person told us, "The food is very good and I can make a choice". A relative told us, "I come most meal times to support (person's name). The food is good and they can always have a choice". We saw that meals looked appetising. We saw some staff assisted people to eat in a caring and appropriate manner.

However, one visitor told us that their relative's cultural dietary needs had not been met effectively and they had raised this as a concern with the previous manager and this had remained a concern for them.

Not all people received the support they needed and in a timely way. In Calthorpe House we saw that some people sat at the dining table for 50 minutes before their lunch was served. In Lawrence and Perrywell House we saw that people who were able to eat independently got their meal quickly, but then there was very little staff intervention or support to prompt or help people. For example, we saw one person started to use their fingers and we saw that another person's plate guard fell off their plate but there was no one available to support either person to ensure they received their meal in a timely way.

We saw that drinks were available and within reach of people being cared for in bed. Where people had been assessed as being at risk of malnutrition we saw that they had been referred to other health care professionals, for example the doctor and dietician services. We saw that advice given by professionals was followed. We saw that people's weight was monitored on a regular basis so that action could be taken if needed to boost or reduce their dietary intake.

People told us that their health needs were regularly monitored and action taken to ensure that appropriate treatment was provided. One person told us, "I feel comfortable talking to staff about my care". Another person told us, "If I need to see the doctor then I can". A relative told us, "I do know that they call the doctor if there is anything wrong".

Systems were in place to ensure that people were supported to maintain good health and receive on-going healthcare support We spoke with two visitors whose relative had needed hospital treatment recently. They told us that they had confidence in the staff monitoring their relative's health care and that staff had kept them fully informed of what had happened. Staff told us that if they observed a change in people's health care that they would immediately let the nurse on duty know. Nurses told us that daily internal meetings with the manager were in place for discussing people whose needs had changed or who they were concerned about.

In Perrywell House we observed that many people were being cared for in bed and we asked the provider about this

Is the service effective?

and their pre admission assessment process. The provider told us that they would be reassessing people's needs to ensure people had the right equipment in place such as specialist chair to sit in, so that they had the choice to access communal areas of the home, and to engage in social opportunities and hobbies and interests if they wanted to. The provider told us that a more robust pre admission assessment would be introduced.

Is the service caring?

Our findings

Although we found that staff were busy during our visit, and training and support for staff had not always been effective we saw good interactions between staff and people that lived in the home. We saw that people were supported with kindness and compassion by staff. People spoke positively about the care they received. One person told us that although they sometimes waited for staff to come to assist them that when they did assist them they were always kind and caring. Another person told us, "The staff are very kind to me they listen to you".

Staff recognized the importance of people's personal appearance and this respected people's dignity. It was a hot day when we visited and some people were sitting in the garden. We saw that sun hats had been provided for people to use. One person told us that staff helped them to put their jewellery on that they liked to wear. We saw that people's spectacles were clean.

We saw that people who remained in bed were dressed in loose, clean clothing so that they were comfortable. We saw that staff entered people's rooms and checked on people to make sure they were cool or warm enough and we saw that people were repositioned in their bed to make sure they were kept comfortable.

During our observations we saw lots of very positive interactions between staff and people that lived in the home. We saw that staff responded to people's request for assistance. One person asked a staff member to fetch their handbag and this was responded to promptly. Another person requested to go to their bedroom and staff supported the person to do this. People requested drinks and assistance with personal care. Although staff were busy they were polite and responded to people as quickly as they could. We saw staff supporting people to move around the home and this was done at the persons pace.

We saw that staff closed people's bedroom door before they attended to people's care. We observed that when people were supported with the aid of a hoist staff made sure people's legs were covered with a blanket which protected their dignity. All the staff we spoke with were able to give us a good account of how they promoted privacy and dignity in everyday practice and demonstrated an understanding of how important it was to do this, when carrying out their role.

Staff showed compassion and empathy with family members whose relative was unwell. We saw that one nurse took time to sit and talk to a family member who was upset. The nurse explained the circumstances to us and described how it was an important part of their role to be available to speak with relatives when needed. A relative told us, "Staff always have time to answer my queries about my relatives care".

Is the service responsive?

Our findings

Everyone we spoke with felt that staff knew their needs and the things that were important to them. One person told us, "I choose when I go to bed and the staff support me to do this. In the morning they knock my door to see if I am ready to get up and come back if I am not". Another person told us, "Staff know my needs and how I like to be supported".

We saw that there was a variance in the support people received to take part in hobbies and interests across the four houses. We saw that in Perry Well House and Lawrence House that staff engaged well with people and facilitated games and quizzes and also spent some time with people individually, for example playing chess, looking at a book and singing a song. In Brooklyn House in the morning we saw that people sat for long periods of time unoccupied and no staff offered people the choice to take part in hobbies or individual interests. However, in the afternoon staff were available and they organised a group session which people said they enjoyed. The provider told us that more staff were being employed with the specific role of supporting people to take part in hobbies and interests to promote people's stimulation and enjoyment.

We observed visitors were made to feel very welcome by staff. Staff spoke to visitors about their relative's care. A relative told us, "The staff are very good and they make me feel welcome. They always offer me a drink and sometimes I have a meal on a Sunday with (person's name), which is really nice".

In each house staff told us that they have access to care records and that they were told when changes had been made to these. Care records showed that people's needs had been reviewed so that changes in their care could be planned.

In Brooklyn house we spoke with staff who cared for people that received intermediate care. This means short term specialist care to people who have been discharged from hospital but need extra support before they return home. We saw that a care plan for a person with epilepsy lacked information about the type and frequency of seizures experienced by the person. In addition, a care plan needed to be implemented about a person's mental health needs. Staff told us that they knew how to meet these needs and we saw that the care records were completed on the second day of our inspection visit.

People told us that they knew how to complain. We saw information displayed about how to make a complaint. One person told us, "I have raised concerns with staff and they have dealt with them to my satisfaction". All of the relatives we spoke with told us that they knew how to raise concerns. One relative told us, "I would have no hesitation in raising my concerns if I needed to. There have been a couple of little things that I spoke with staff about. When I pointed these things out they were dealt with promptly".

Most people and their representatives knew how to complain, however some relatives who had complained, had not been satisfied that their complaint had been dealt with in line with the provider's procedure. Before we inspected the service some relatives had contacted us and told us that their concerns and complaints had not been dealt with to their satisfaction by the previous manager. We listened to their concerns, used some of the information to inform our inspection planning and we also let the provider know about the complaints so they could respond. The provider told us that they had met with the families and resolved their concerns. During the inspection another relative spoke with us and told us about their dissatisfaction with how their concerns had been dealt with by the previous management team.

Is the service well-led?

Our findings

In June 2014 the provider had shared with us their concerns about the management arrangements for the home. They had replaced the previous management team and interim management arrangements were in place when we visited. However, although the provider had recognised the shortfalls they had not acted promptly enough to ensure the service was well led. We found beaches relating to staffing levels, failure to make DoLS applications, lack of staff training and support, and failure to monitor the service effectively. The provider had not demonstrated good management and leadership.

The provider did not have a robust system in place to determine safe staffing levels. The PIR told us that the provider would ensure that unit managers would have their supernumerary hours weekly so they could oversee the effective running of each house; this had not been implemented when we visited.

The providers PIR told us that no one had restrictions in place. However, when we inspected we found that this was not the case. We found that not all deprivations of people's liberty had been identified and managed.

We found that staff had not received the training and support they needed to carry out their role effectively.

We saw records of audits that had been carried out to assess the quality of the service. However these had not been effective in identifying the risks relating to the health, welfare and safety of people. We saw that a report was compiled to monitor the number of falls, accidents, complaints and safeguarding incidents. The report did not provide any analysis of this information to identify trends within the home and to inform where improvements were needed.

We asked about resident and relative meetings. We were told by the acting manager that no feedback surveys or meetings had taken place with the people who lived there or their relatives and no surveys had been completed to ask people their views about the service provision.

Staff members told us that staff meetings had become infrequent and minutes of meetings looked at confirmed this. Staff told us that the reason for this was because of staff shortage. This meant that staff had not been provided with an opportunity to be asked their views about the service, and to be kept updated on current good practice.

The service had not demonstrated that systems in place to regularly assess and monitor the service were effective. This was a breach in Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider and interim manager responded positively to the feedback we gave during inspection process. They took immediate action to make improvements in the service. For example they told us that unit managers would be made supernumerary immediately, so that they were available to provide effective oversight of the running of each of the houses. They also told us that steps had been taken to provide staff with the training and support needed to carry out their role. They commenced making DoLS applications to the local authority.

All the staff we spoke with understood their right to share any concerns about the care at the home. All the staff we spoke with were aware of the provider's whistleblowing policy. Staff told us that they would raise concerns if they needed to. There was a core team of staff who demonstrated that they really cared about their role and wanted to do a good job. Staff told us that the home had endured a period of changes in management. Some staff told us that this had been difficult and stable leadership in the home was needed.

We had been informed of reportable incidents as required by CQC and the acting manager demonstrated they were aware of when we should be made aware of events that had taken place in the home. We saw that steps had been taken to respond more effectively to complaints and we saw an example of this during our visit.

We were notified that an experienced manager from one of the providers other registered services had been appointed to manage the service from August 2014 and that they had commenced the registration process with CQC.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The provider had not taken proper steps to ensure that people who used the services were protected against the risks associated with insufficient staffing.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The provider had failed to ensure that an effective system was in place to prevent people being unnecessarily deprived of their liberty.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The provider had not taken proper steps to ensure that staff were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to people safely.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The provider had not taken proper steps to regularly assess and monitor the service timely and effectively.**