Barchester Healthcare Homes Limited

Atfield House

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 12 and 13 July 2016. During the inspection, we found a breach of a legal requirement as the service did not always follow safe practices. A wound management care plan was not being followed as directed by the tissue viability nurse and the service was not formally recording that they monitored people during the day to evidence that there were measures in place to minimise identified risks to people, particularly those people unable to use call bells.

After the inspection, the provider submitted an action plan detailing what they would do to meet the legal requirement in relation to the breach.

We undertook this unannounced focused inspection on 10 January 2017 to check that the provider had followed their plan and to confirm that they now met the legal requirement. This report only covers our findings in relation to the requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Atfield House on our website at www.cqc.org.uk.

Atfield House is part of Barchester Healthcare Homes Limited and provides care with nursing for up to 63 people. The home has three units consisting of two units for physically frail and older people and a third unit for people living with dementia. At the time of our inspection there were 57 people using the service.

The registered manager had been in post since 2012. 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.

At our focused inspection on 10 January 2017, we found that the provider had followed their plan of action, dated 13 October 2016 and that the legal requirement had been met.

Wounds were initially seen and entered onto the electronic database by the deputy manager. The deputy manager was present when wounds were dressed and people's care plans were audited weekly. The managers and nurses had a daily meeting, which included wound management as an agenda item. This provided the opportunity to share their own observations and update their colleagues on any external healthcare professionals' visits.

The service had care plans for falls, call bell assessments and since the last inspection had begun to record hourly monitoring of people using the service.

Audits by the deputy manager were effective in identifying any gaps in the care plans and resolving them.

We saw improvements to how PRN (as required) medicines were recorded and topical creams had body charts with clear instructions on how to administer the creams.

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.

Wound management had improved and the deputy manager had greater involvement with wound care which provided them with an overall view of how people using the service were receiving care.

Managers and nurses communicated clearly with each other through established processes such as daily meetings and audits to provide people with care appropriate to their individual needs.

The service monitored and recorded hourly checks on all people using the service to minimise risk.

PRN (as required) medicines and topical cream administration was recorded correctly which meant people were protected from the risk of not receiving their medicines as prescribed.

Atfield House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook a focused inspection on 10 January 2017. It was unannounced and conducted by a single inspector. This inspection was carried out to check that improvements to meet the legal requirement planned by the provider after our 12 and 13 July 2016 inspection had been made. The service was inspected against one of the five questions we ask about services: Is the service safe?

Prior to the inspection, we looked at all the information we held on the service including the last inspection report, the provider's action plan which set out the action they stated they would take to meet the legal requirement, notifications of significant events and safeguarding alerts. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

During the inspection, we spoke with the registered manager, the deputy manager, a registered nurse and a person using the service. We looked at care plans for six people who used the service and checked three MAR and body charts to ensure people were receiving care safely.

Good

Is the service safe?

Our findings

At the inspection on 12 and 13 July 2016, we found a wound management care plan was not being followed and the service was not formally recording that they monitored people during the day to evidence that there were measures in place to minimise identified risks to people. This meant we could not be sure people were receiving safe care. The provider supplied us with an action plan detailing how they would make the necessary improvements by 13 October 2016.

On 10 January 2017, there was evidence that the provider had improved their practice and put in place extra measures as stated in their action plan. To address wound care management being followed, we saw minutes from a meeting held with the nurses on 01 September 2016 that highlighted the concerns raised by the Care Quality Commission and instructed nurses who accompanied outside healthcare professionals when visiting people who use the service, to complete the paperwork regarding the visit. We looked at the care plans for four people and saw wound assessment records completed by the nurses, appropriate referrals made to other professionals such as the tissue viability nurse and evidence that the wounds were healing.

We saw records for January 2017 of the meetings the managers and registered nurses held each morning. Each set of minutes had a specific box to note any people who required wound care. This meant information was shared and management plans were developed and implemented in response to any concerns identified to support people's safety and wellbeing. We saw on 5 January 2017, a nurse raised at the meeting that a person should be referred to the tissue viability nurse. We saw the appointment was recorded in the person's file and in the diary so all staff were aware of the appointment and the outcomes.

The deputy manager was present when all wound dressing were being changed and dressed so they were aware of any concerns or follow up required and this could be shared in the daily nurses' meetings and actioned. Additionally an electronic record of wound management was kept by the service. The deputy manager saw all new wounds prior to entering them on the system.

To address the issue of monitoring people, the action plan noted the service would implement an hourly checks document and attach it to the daily paperwork submitted each day to the managers. We saw daily checks were being completed hourly by the nurse in charge 24 hours a day. The registered manager told us that initially they were only monitoring people who were unable to use call bells but the nurses raised the benefits of monitoring all people. As a result, all people using the service were being monitored.

We looked at falls care plans for five people using the service. We saw care plans were reviewed monthly by the nurses and the deputy manager audited a minimum of eight files per month. We saw in a November 2016 audit the deputy manager had requested a call bell needs assessment, the nurse had updated the person's care plan and we saw that they were being monitored hourly and it was recorded. This indicated effective auditing, good communication and sustained implementation of the action plan. We asked one person who used the service what happened when they had a fall. The person told us "I am looked after very carefully" and explained the staff had used a hoist to move them and the doctor had examined them. The

person showed us their call bell was in reach and told us if they rang it, a member of staff would come and "and they act upon it of course."

At the inspection on 12 and 13 July 2016, we saw not all people's prescribed creams had body maps to show where creams should be applied, nor was it documented when creams were meant to be applied. This meant people were at risk of not receiving their treatment correctly. Additionally we noted that PRN (as required) medicines were not always documented in the PRN section of the MAR chart when PRN medicine was administered. We recommended that the provider maintain robust systems to ensure the proper and safe management of medicines at all times

On 10 January 2017, we saw creams were entered on the MAR charts and the provider had created a separate file that had charts for topical creams. The body charts included individual instructions for how and where to administer the creams.

There were only two people who received PRN medicines and we saw that this was being recorded correctly on the MAR charts. The service had appropriate PRN protocols in place and since the last inspection had introduced an additional record called Medicines Notes that recorded the PRN medicines given and the reason why. This meant people were receiving their medicines correctly and in a safe way.

Since the inspection on 12 and 13 July 2016, the provider had improved their service delivery by implementing the changes recorded in their action plan which resulted in more effective care plan management, monitoring and medicines administration.