Grandcross Limited

Yatton Hall Care Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out a focused, unannounced inspection of Yatton Hall Care Home on 8 August 2017. Prior to this inspection, we had received concerns from external sources about the health, safety and welfare of some of the people living at the service. The concerns related to some people not receiving their medicines as prescribed and the deployment of staff within the service and the impact this had on the care and support people received. Additional concerns we received related to the identification and reporting of potential safeguarding concerns and moving and handling practice.

We undertook this focused inspection to ensure that people living in the service were safe, and that there were sufficient staffing arrangements in place to make sure people's care needs were being met. We reviewed the medicines management in the service, and spoke with staff to establish their knowledge in relation to identifying and reporting safeguarding concerns. We looked at the training staff received in relation to moving and handling people and what systems were in place to review falls or incidents. This report only covers our findings in relation to these areas.

When we last inspected Yatton Hall Care Home in November 2016, we found no breaches of the legal requirements and the service was rated 'Good' overall. You can read the report from our last comprehensive inspection, by selecting the 'All reports' link for Yatton Hall Care Home on our website at www.cqc.org

Following this inspection, the current overall rating for the service remains at 'Good.'

Yatton Hall Care Home is registered to provide accommodation for up to 48 people. At the time of our visit, 38 people were living at the service.

A registered manager was in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People were not fully protected against the risks associated with medicines. Records had not been accurately maintained by nursing staff. This placed people at risk as staff were unable to confirm if a person had received their prescribed medicine the day prior to our inspection.

We found that some records were not clear when detailing how to meet people's care needs in relation to reducing their risk of developing a pressure ulcer. This was due to no record detailing the support people received during daytime hours. We found some air mattresses were also incorrectly set. Improvements were required in the risk management of epilepsy management. Improvements were also required when people were identified as losing weight and the recording of all referrals made when nutritional risks were identified.

People at the service were very positive when speaking about their care experiences and the staff that supported them. All said they felt very safe in the service. People told us there were sufficient staff to support them and staff told us there were sufficient staff to meet people's needs, but expressed frustration at frequent short notice sickness from colleagues.

Staff understood their obligations around safeguarding adults and felt confident matters would be addressed by the service management. Staff were knowledgeable about external agencies they could contact to raise safeguarding concerns with should the need be required. Staff received moving and handling training to ensure safe practice and their competency was assessed.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

Medicines were not consistently managed safely.

Care needs were not always being met safely or risks mitigated.

People spoke very positively about feeling safe.

There were sufficient staff to support people and meet their needs.

Incidents and accidents were monitored.

Yatton Hall 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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out a focused inspection of Yatton Hall Care Home on 8 August 2017 following concerns being raised. Concerns were related to the health, safety and welfare of some of the people living at the service. This included some people not receiving their medicines as prescribed and the deployment of staff within the service. Additional concerns we received related to the identification and reporting of potential safeguarding concerns and poor moving and handling practice.

The inspection was unannounced and undertaken by two adult social care inspectors. The inspection involved inspecting the service against one of the five questions we ask which was, 'Is the service safe?'

During our visit we spoke with 10 people who used the service. We spoke with the registered manager and seven staff including a registered nurse. We looked at three people's care records, monitoring records and additional records relating to the management of the service. This included staffing rotas, incident and accident analysis records and staff training records.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely which placed people at risk. During our review of the medicines management, we identified incomplete records relating to if people had received their medicines as prescribed that day. For example, one person's Medicine Administration Records (MAR) confirmed they were prescribed a medicine to control epileptic seizures twice a day. This person's MAR had a missing signature. This meant it was not clear if the person had received their prescribed medicine on this day. We raised this with the nurse on duty. The nurse on duty was unable to confirm if the person had received their epilepsy medicines as prescribed the day before our inspection.

The person MAR had not been signed on 06/08/2017 for the 18:30hrs administration. We asked the nurse to check the stock of these medicines. This was so we could establish if the medicine had been administered. The nurse was unable to confirm what the stock level of the medicine should be because there was no record that confirmed the stock level carried over from the month before. This is important as by keeping a carried over amount of medicines means the service can identify any errors in administering medicines. The nurse was not able to confirm whether the person had received their medicine as prescribed. We discussed this with the registered manager who said any recording omissions on MAR charts were reported using the provider's internal monitoring system. However, these shortfalls had not been identified or addressed by the nursing staff and was identified by the inspection team.

We also identified an additional 14 separate missing MAR records where there was no signature to confirm if people had been administered their prescribed medicines. By having no record, this meant it was unclear why the medicine had not been administered. When people had their medicines administered via the multi dosing system supplied by the pharmacy, it was easy for staff to check current balances or if people had received their prescribed medicines. However, those people who did not have this multi dosing system had no accurate records that confirmed if people had received medicines as prescribed which placed them at risk.

Records relating to the medicines fridge temperature were monitored daily. The record had been completed in full. The chart stated, "Safe zone 2 - 60 C." However, we saw that on 30/07/2017, the temperature of the fridge had been recorded as "9" and was outside the recorded safe temperature zone. There was nothing documented to demonstrate that this had been noted by staff, or that any action had been taken to ensure that the medicines within the fridge, which included insulin that requires an ideal storage temperature of 2 - 60 C to ensure effectiveness, were still safe to use. We discussed this with the registered manager who after speaking to the nurse told us that the nurse had informed them the temperature had been checked again an hour later and was found to be within a safe range, however these actions had not been recorded on the monitoring form.

There were photos of people at the front of their MAR and these had been dated. This is important as staff administering medicines that were unfamiliar with people, such as agency staff, would be able to recognise people easily. People's preferences in relation to how they preferred to take their medicines had been recorded in care plans. Some people had been prescribed medicines on an, "As required" basis. This

included medicines such as paracetamol and ibuprofen. However, there were no protocols in place to inform staff when and why people might require these additional medicines. We also found that some topical medicine administration charts had not always been completed in full.

This was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014.

We found examples of care and treatment that did not ensure people were consistently cared for safely. All of the care plans we reviewed contained risk assessments for areas such as falls, moving and handling, nutrition and skin integrity. All of the risk assessments had been reviewed monthly. Where risks had been identified care plans generally, but not always, contained clear guidance for staff on how to reduce the risks. We found good examples of risk management, however some information was inconsistent. Good examples showed when people required the use of equipment to transfer safely, it detailed the type of hoist and size of sling to be used. Additionally, when people used walking aids, such as frames, these were also documented and the guidance for staff was clear on how to keep people safe, such keeping the area clutter free and ensuring people used their walking aids.

When people were assessed as being at risk of pressure ulcers care plans detailed how staff should reduce the risk, although at times this information was limited. For example, one person's plan confirmed they had been assessed as a being at, "Very high risk" of skin breakdown. The guidance for staff was recorded as, "When in bed reposition 3-4 hourly. Air mattress set at 4. Air pressure relieving cushion in chair." The plan did not inform staff to also change the person's position during the day in order to relieve the pressure. The repositioning charts reflected this. On some occasions, it had been recorded by staff that the person had been sat in a chair for up to 12 hours at a time. Being sat in a chair for 12 hours, even on a pressure relieving cushion, could increase the risk of pressure ulcerations and could also be uncomfortable for the person. There was nothing documented on the charts to show that staff had stood the person up throughout the day or if their position had changed. We looked at repositioning charts for another person which also appeared to show they had on occasions been sat in their armchair for up to 12 hours at a time. This meant it was not clear if the person had changed position during this time period to reduce the associated risks with developing pressure ulcers.

We reviewed a sample of air mattresses to ensure they were correctly set to manage people's pressure ulcer risks. It was not clear how these were monitored by staff to ensure they were set correctly. The mattresses needed to be set according to people's weights. The required mattress settings were documented in the person's care plans, but the actual setting on some of the air mattresses we looked at did not always correspond with their care plan setting. Although we found some mattresses were correctly set. We found others were not. For example, in one person's plan it was documented the mattress should be set at setting 4. When we checked, the mattress was set at 8. This would place the person at risk if they used the mattress at this setting.

We found two another people who had their mattress incorrectly set. For example, one person had their mattress set at 4. Their care plan stated the setting should be 2-3. Another person had their mattress set for a weight of 80kg when their latest recorded weight was 70kg. It was unclear how the settings were monitored, because although there was a section on position change charts for the mattress setting to be checked and recorded, these were all blank. Which meant it was not evident if staff had ensured the mattresses were accurately set or being checked. We asked one member of staff how they knew what the mattress setting should be and they said, "I think the maintenance man sets them up when people first move in." This meant people at risk of pressure ulcers could be at increased risk due to their mattresses not being accurately set.

We looked at the care plan for one person diagnosed with epilepsy. Although the plan clearly detailed the symptoms the person might display prior to and during a seizure, there was no guidance for staff on what to do if this happened. This meant there was a risk that staff would not know how to keep the person safe during a seizure or how to treat it and help ensure the person's safety. This was currently a higher risk at the service due to the use of agency nurses and staff and their potential unfamiliar knowledge of people and their needs.

People had been assessed for the risk of malnutrition and some people were having their food and fluid intake monitored. However, the quality of these monitoring charts was poor and did not indicate that people were always being offered or having enough to eat and drink. For example, we looked at the food and fluid monitoring charts for one person. On two separate days, staff had documented that the person had only 200mls of fluid to drink. There was no other records that confirmed the person had been offered fluids but had refused or if this amount was a cause for concern. This presented a risk of dehydration and there was no other records that confirmed it had been identified or any action had been taken by the nursing staff.

Another person's care records evidenced they had lost weight earlier in the year. The person had been weighed monthly, but the actual date of weighing was not always recorded. Their weight on 27/03/2017 was documented as 88.65kg. The next documented weight was recorded as, "April 17" where it was noted that the person had lost 7.15kg. Because there was no accurate date recorded, it was unclear over exactly how many days this weight loss had happened. On 31/05/2017, staff had documented, "Has been reweighed a few times, but weight was the same. Has lost 7.6 kg. Datix (internal system used by provider) done, NOK informed. Manager and staff informed to continue food and fluid monitoring." On the 14/06/2017 records confirmed the person was referred to their GP, "For losing weight." This meant there was a risk that staff had taken up to three months to escalate the weight loss to the GP. We discussed this with the registered manager who said the GP had been informed of the weight loss earlier, and the person had been prescribed nutritional supplements, but this was not clear from the records seen. This meant the service was not acting promptly when the person had been losing weight. Records were not always complete to provide an accurate record of action taken and dates completed.

All of the people we spoke with, without exception, spoke positively about living at the service and the staff employed there. Everyone commented on how they felt safe and said that they were supported by caring staff. One person we spoke with told us, "I do feel safe, very safe. All the staff are lovely, they look after me wonderfully." Another person said, "I am safe here, they will look after me if I need them to." A further comment we received was, "I can't really say anything other than perfect. They can't do enough for you really, if you ask for things they get done."

People felt there were sufficient staff on duty to support them. We did not receive any negative comments. People told us their needs were met by staff. One person we spoke with said, "There are staff around if I need them." Another person said, "I've not had to use the bell, there's always somebody about." We spoke with staff about the current staffing levels. All said that the current number of staff used ensured people's needs are met timely.

It was evident that during our conversations with staff there was a sense of frustration at the frequency of short notice, unplanned sickness of their colleagues and the impact it had on staff and people. This was echoed by the registered manager. One staff member commented, "It works well when everybody turns up." Another said, "When all are here - it's like clockwork." Another staff member described short notice staff sickness as, "Being the norm, it's expected."

We reviewed the current and projected staffing numbers. The registered manager explained how they planned ahead which allowed them to try and ensure sufficient staff were deployed in line with people's assessed needs. The service was currently recruiting for vacancies. Where hours were required to be covered, additional shifts were initially offered to current staff members or a member of the small bank staff the service had. Should it be required, the service used external agency staff to cover nursing and care staff vacancies as a further resource.

The provider had minimised the risk of people being exposed to the risk of abuse as appropriate arrangements to identify and respond to the risk of abuse were in place. There were appropriate policies in place for safeguarding and whistleblowing and staff had received training. Staff understood their duties in relation to reporting suspected or actual abuse. They explained how they would feel confident to report concerns internally to senior management or to external agencies such as the Care Quality Commission or the local safeguarding team. Staff were confident that concerns would be acted upon by their management team if reported.

Staff had received training in moving and handling people to ensure any practices were safe. The service had in-house trainers in moving and handling and training records showed staff had received current training and were competency assessed following this training. We reviewed a sample of the completed competency assessments. People we spoke with that received support from staff in being moved by staff with the use of a hoist did not raise any concerns. All said that staff were competent and transfers were performed well. Where incidents had been reported in relation to moving and handling, an investigation had been completed and appropriate records maintained.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not consistently managed safely. Regulation 12(2)(g)