

Barchester Healthcare Homes Limited

Lanercost House - Carlyle Suite

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on the 18 July 2018 and was unannounced. When we previously inspected this service in November 2017 we rated it as 'Good'. We inspected the service against two of the five questions we ask about services: is the service well led? and is the service safe? This is because concerns had been raised that the service was not meeting some legal requirements. No risks, concerns or significant improvement were identified in the remaining Key Questions through our on-going monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection..

Lanercost House - Carlyle Suite (Carlyle Suite) is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Carlyle Suite accommodates up to 15 people in one purpose-built building. At the time of our inspection 14 people were living there. The service is located in the grounds of Lanercost House care home.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found one breach of regulation. This related to people's risk assessments and the way staff implemented care plans based upon them.

You can see what action we told the provider to take at the back of the full version of the report.

We also made recommendations that the service continue to develop its quality assurance systems.

This is the second time the service has been rated Requires Improvement.

Risk assessments and care plans that should have provided guidance for staff in the home were not always followed or reviewed correctly. We found evidence that staff were not always up-to-date with the training required to safely implement strategies identified in risk assessments and care plans that were designed to keep people safe.

The staff team told us they understood how to protect vulnerable adults from harm and abuse. Staff talked to us about how they would identify any issues and how they would report. Medicines were managed appropriately and equipment was properly maintained and serviced.

Business continuity plans were in place and each person had a personal evacuation plan in place to help

keep them safe in the event of a fire or flood. Any accidents or incidents had been reported to the Care Quality Commission as necessary. The home was clean and odour free.

Quality assurance systems were in place. The registered manager had recently changed the way they managed Lanercost House - Carlyle Suite and increased the amount of audits taking place in order to drive up quality and improve the service. We made a recommendation about this.

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 always safe.

Staff were not following risk assessments and their associated care plans correctly, outcomes were not correctly recorded and staff were not thoroughly trained in important aspects of care and support designed to keep people safe from harm.

Staff knew how to report abuse and who to report it to.

Medicines were well managed.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

The registered manager had recently changed management arrangements in the service and brought in additional staff to drive up quality.

There were regular staff meetings where potential improvements and changes could be discussed.

Relatives and staff knew the registered manager well and were positive in their feedback around their leadership.

Lanercost House - Carlyle Suite

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.

The inspection was prompted in part by notification of an incident which involved a person using the service. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information about the incident shared with CQC, by the police and local safeguarding authority indicated potential concerns about the management of risk associated with moving and handling and personal care including pressure care. This inspection examined those risks.

This inspection took place on 18 July 2018 and was unannounced. The inspection was carried out by one adult social care inspector.

Prior to the inspection we gathered and reviewed information we held about the service including statutory notifications we had received. Statutory notifications notify us of deaths and other incidents that occur within the service, which when submitted enable the Commission to monitor any issues or areas of concern. We spoke with health and social care professionals including social workers and representatives of the local safeguarding authority and asked their opinion of the service. We reviewed the provider information return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made the judgements in this report.

We 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 with us. We reviewed the care records of five people who lived at Lanercost House - Carlyle Suite. We examined three staff files. We spoke with four people who

used the service and three relatives. We also spoke with nine members of staff including care staff, nurses and the registered manager. We reviewed records relating to the safety and management of the care and the premises. We walked round the building, its grounds and, with permission, looked at people's bedrooms.

Is the service safe?

Our findings

People we observed appeared calm and comfortable at the home. When asked if they thought people were safe a relative commented, "Definitely, I have no worries or concerns."

We looked at people's care plans and saw risk assessments for each person covering areas such as mobility and continence. The registered manager carried out generic risk assessments on the building including fire risk and health and safety risks. The risk assessments undertaken identified ways to minimise risk to people who used the service and helped keep them safe from harm and were accompanied by care plans which detailed how staff were to achieve this. We looked at training records to check that staff were competent and correctly trained to carry out tasks identified in the risk assessments and the accompanying care plans. When we examined how information from risk assessments and their accompanying care plans was being implemented we found this was not always being done correctly.

For example, one person had a moving and handling assessment that had been carried out by an occupational therapist. It clearly showed how to move the person using a hoist and highlighted risks and safety concerns. However, the information from the assessment had not been transferred into the service's care plan. Subsequently staff were not following best and safe practice when using a hoist to help transfer the person from their bed to a chair. The occupational therapist had written to the service highlighting these issues. They told us, "I have found some instances where staff aren't following it [the risk assessment], I have discussed this with the staff." This meant that staff were not always following advice from healthcare professionals that was given in order to keep people safe.

We looked at another person's risk assessment and accompanying care plan. It stated that at times the person, who lived with dementia, could become agitated and upset when in need of personal care. The assessments correctly identified the person's dignity had to be balanced with the distress caused. The plan stated that to avoid harm to both the person and staff the person may have to be restrained during these times. This meant that staff would place their hands over the person's hands to stop the person from harming themselves or striking the staff. The assessment called for staff to be appropriately trained in this area, when we examined training records of 15 staff at Lanercost House - Carlyle suite we found only four staff had the correct training, four had no training and seven had training that had expired. This indicated the majority of staff had experience in supporting people in this way but had not met training requirements highlighted in the assessment and care plan.

As part of any assessment process it is important for staff to complete relevant records. Records can then be reviewed and assessments up-dated accordingly. We found examples of repositioning charts not being completed. Repositioning charts are a record of how often people are moved to protect the integrity of their skin. People who are placed on repositioning charts are generally at risk of their skin breaking down and may go on to develop pressure ulcers, also known as bed sores. The failure to complete these charts correctly made it appear that people were at risk of developing pressure ulcers. However, we noted that there was no-one in the service with a pressure ulcer and concluded that people were being moved correctly and records were not being completed to demonstrate this. Incomplete record keeping affects how risk

assessments are reviewed, a review cannot be carried out correctly if important information is missing.

The above examples demonstrated a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We found personal emergency evacuation plans (PEEPs) in place for each person. These were very detailed and described the support each person would need to be moved or evacuated in the event of an emergency. A business continuity plan was in place for staff and management to follow in the event of a range of unforeseen circumstances arising, such as a fire or loss of power to the building.

Health and safety checks were carried out regularly to ensure people's safety. These included a range of checks including for fire safety, the building, legionella control measures, window restrictors and checks and servicing of equipment used in care delivery, such as hoists and wheelchairs. Risk assessments related to the building and environment were in place.

Staffing levels within the service were sufficient to meet people's needs on the day of our inspection and we observed people having their needs met in a timely manner. Staff told us they thought staffing levels were, 'normally enough' and that colleagues from the care home next door came across to help out if needed. Rotas reflected what staff had told us.

We looked at the recruitment and selection processes used by the provider. We saw that all staff had received a disclosure and barring service check (DBS). A DBS check shows whether prospective staff have a criminal record or are barred from working with vulnerable people. In addition staff had up to date references from previous employers which showed they were of good character and suitable to work with older people with vulnerabilities.

We spoke with members of staff and asked them how they safeguarded the people who used their service from abuse. Staff were able to tell us about different kinds of abuse such as physical, financial or emotional. They told us they would speak with the registered manager if they suspected abuse was taking place. This meant staff knew how to identify and report abuse. We spoke with the registered manager who demonstrated their knowledge on how to report issues relating to abuse and safeguarding. There was a whistleblowing policy in place that instructed staff on what to do if they had concerns about the practice of a colleague.

We noted that the home was clean and odour free. Domestic staff were cleaning throughout our inspection. There were cleaning schedules in place to ensure that all areas received a regular clean. Staff had the necessary training in place to help them manage and prevent infection. Personal protective equipment such as disposable gloves and aprons were readily available.

The safe administration of medicines was outlined in policies and procedures at the service. Medicines were administered by staff trained to do so whose competencies were regularly scrutinised by senior staff. All medicines were stored safely in a locked cupboard and medicines trolley along with the appropriate records. There was a fridge for medicines that required cool storage. If required controlled drugs could be securely stored and monitored. We carried out spot checks on medicine administration records and found them to be correct. There was guidance on the use of 'when required' medicines which were accompanied by a corresponding care plan in people's care records. The ordering and disposal of medicines was carried out in conjunction with a local pharmacy.

Is the service well-led?

Our findings

There was a registered manager in place at the home. They had been registered since 2015.

We spoke with the staff about leadership in the service. They told us, "You can always go to the [registered] manager if you have any concerns." And, "We see the [registered] manager every day and their deputy." A relative told us the registered manager was, "Very nice."

Following concerns raised the registered manager had recently changed management arrangements in the service. They had based themselves in the service and were doing three 'walk rounds' a day in which they checked the service and to ensure support being provided was satisfactory. They continued to use quality assurance systems which included regular safety checks, audits of cleanliness and hygiene and medicines. All audits and checks were shared with the provider to help them monitor the performance of the service. In addition, they had commissioned extra audits of the service and brought in more staff to carry out these audits. On the day of our inspection a member of staff was auditing care records. We brought our findings around risk assessments and associated care plans to their attention. The member of staff and the registered manager immediately rectified the issues and devised systems to ensure that these changes were sustained, for example shift by shift checks for repositioning charts.

We recommended the service continued to improve its quality assurance systems and we will continue to monitor this.

During the inspection, the registered manager and their team were keen to work with us in an open and transparent way. All documentation we requested was produced for us promptly and was stored according to data protection guidelines. The registered manager was aware of their duty to inform us of different incidents and we saw evidence that this had been done in line with the regulations. Records were kept of incidents, issues and complaints and these were all regularly reviewed by the registered manager in order to identify trends and specific issues.

There were regular staff meetings so that important issues could be discussed and any up-dates could be shared. Staff meeting minutes were clearly recorded so that members of staff who were not able to attend could read them afterwards. We observed a culture where the staff and the registered manager had worked hard to improve the service. There was also evidence within records that people and, where possible, families were consulted about the care and support the service provided. The service consulted with people and their relatives in a variety of ways including face-to-face formal meetings and written surveys.

The ratings from the previous inspection were displayed in the home as required and on the provider's website.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	service failing to assess the risks to the health and safety of service users, and doing all that was reasonably practicable to mitigate the risks. This was a breach of Regulation 12, (1) (2) (a) (b) (c)