Czajka Properties Limited

Staveley Birkleas Nursing Home

Inspection report

8-10 Staveley Road
Nab Wood
Shipley
West Yorkshire
BD18 4HD

Tel: 01274588288
Website: www.czajka.co.uk/staveley.html

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Staveley Birkleas is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection (The care home) accommodates 60 people in one adapted building. On the day of the inspection there were 54 people living in the home.

We undertook an unannounced focused inspection of Staveley Birkleas on 24 May 2018. This inspection was conducted following information of concern which we received which included a number of safeguarding concerns about the service. The primary aim of the inspection was to check the safety of the service and the ongoing risk of harm to people. The team inspected the service against two of the five questions we ask about services; 'Is the service Safe?' and 'Is the service Well Led?'

At the last comprehensive inspection in January 2018 we found the provider was in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations. This was in relation to 'Safe Care and Treatment' and 'Good Governance'. Following the inspection, the provider sent us an action plan stating it would be fully compliant with the regulations by 1 June 2018. We undertook this inspection before this date, because we needed to promptly check the safety of the service. At this inspection we found the service was still in breach of these regulations. We found a number of issues and lack of progress in becoming compliant with the regulation. Due to the number of issues we found we rated the 'Is the service Safe?' domain as 'Inadequate'. We saw some improvements had been made to the management structure within the home which gave us some assurance that this would lead to improvements to the safety of the service in the future. Overall, we kept the service's rating at 'Requires Improvement'.

A registered manager was in place. 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.

Risks to people's health and safety were not properly assessed. Risk assessment and care plan documents were not always present or up-to-date. Incident management processes needed improving. Incident descriptions and action taken was not always recorded which did not provide us with assurance that action had been taken to mitigate risks.

There was a lack of protocols and information available for staff to help ensure 'as required' medicines were given consistently and appropriately.

Nurse staffing levels had been improved since our last inspection. However, some people were not consistently receiving their contracted hours of one to one support. These people needed these for

companionship, activity and to reduce distress.

The service had introduced clinical leads into the home to help improve nursing practice and assist with monitoring and checking how the service was operating. However, we identified continued risks to people's safety which should have been prevented from happening through the operation of robust systems of governance and audit.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. You can see what action we asked the provider to take at the back of the full version of this 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?

Inadequate

The service was not safe.

Protocols and guidance were not in place for the administration of 'as required' medicines to aid consistent and appropriate support.

Risk management processes were not suitably robust. Comprehensive care plans were not always in place following people's admission to the home.

Care plans and risk assessments were not always updated following incidents.

Some people were not consistently receiving their one to one support from staff.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Some improvements had been made to management structures with clinical leads now in post to help improve clinical practice. However improvement had not yet been embedded into practice However, systems to assess, monitor and improve the service were not effective, and the service continued to be in breach of regulation.

Staveley Birkleas Nursing 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.

This inspection took place on 24 March 2018 and was unannounced. The inspection was completed by two inspectors. Prior to the inspection we reviewed recent notifications received from the provider and spoke with the local authority safeguarding and commissioning teams. The inspection took place due to concerns raised from the notifications and information we received in relation to managing risk within the home and keeping people safe.

We looked at elements of six people's care files, medicine records, staff rota's and incident forms. We spoke with the provider, senior management, registered manager, clinical lead, two nurses, a shift leader and a senior care worker. We spoke with two people who used the service. Following the inspection we requested further documents from the registered manager to follow up queries we raised during the inspection. We used all this information to make a judgement about the service.

Inadequate

Is the service safe?

Our findings

At the last inspection in January 2018 we rated the 'Is the service safe?' domain as 'Requires Improvement.' Although at this inspection we did not look at the whole safe domain, we identified widespread concerns regarding risk management processes within the home which did not give us assurance about the ongoing management of risk. It is because of this that we have rated the domain as 'Inadequate'.

We found improvements were needed to the way 'as required' medicines were managed. One person's medication administration record (MAR) showed they had been prescribed a pain relieving gel, to be applied three times as day, as required. There were no details of where the gel should be applied or what it was for. The nurses on duty were not able to tell us what it was for and the MAR for May 2018 showed it had not been applied. We also saw this person had been prescribed a pain killer to be taken 'as required.' There was no protocol in place to provide staff with further information on when to give. We reviewed this person's daily records and saw they had complained of pain and a care worker had told the nurse. However, when we checked their MAR no pain relief had been administered showing no action had been taken to relieve the person's pain. Another person was prescribed three medicines to help relieve constipation. Although the nurse on duty was able to tell us when and in which priority order these would be applied, there was no protocol or care plan detailing how this was to be managed. This increased the risk of inconsistent care and support being provided dependant on which staff member was on duty.

One person was receiving their medicines hidden (covert) in their drinks. This had been agreed with the GP and staff as being in their 'best interest.' However, there was no evidence in the care file of the pharmacist being involved in the decision making process to ensure that the medicines were suitable to be given in a drink.

We found risk management processes were not always suitable or sufficient. This was especially of concern due to the complex nature of many of the people's needs within the home. Care planning did not demonstrate that risks to people's health and safety had been assessed and mitigated. Some examples of this are as follows. Prior to the inspection concerns were raised with us that the pre-admission process was not robust enough. We looked at one person's records and saw their pre-admission assessment had been poorly completed with inaccurate and incomplete information about their sight, oral health and pain management. This pre-assessment had not been signed or dated by the nurse who had completed it. This was a risk to the person's safety as a robust pre-admission assessment had not been carried out to help ensure consistent care was provided as soon as the person moved into the home. Another person had lived at the home for approximately eight weeks before a care plan had been written about the management of their diabetes.

We saw one person who was very thin. Their weight had not been recorded as they refused to be weighed. We looked at their eating and drinking care plan and there was nothing recorded about improving their dietary intake. Records of the meals they were eating were being made, however, mid-morning, mid-afternoon and supper meals and snacks had rarely been documented. This demonstrated the risk assessment and ongoing monitoring for this person was not sufficient.

Another person's care records stated that they refused to be weight and their weight records stated "looks to have lost weight." Their eating and drinking care plan had not been updated to acknowledge this demonstrating that risk management processes were not suitably responsive.

A person, who had significant needs, did not have a full care plan or a full suite of risk assessments. This meant there was little guidance for staff about what they needed to do to meet their needs. We saw they had a urinary catheter in place and there had been a problem with this. A nurse had completed a 'bladder wash,' but there was no care plan in place regarding the management of the catheter or the action to be taken if there was a problem.

Another person had been assessed as being at high risk of developing pressure sores. The instructions in the care plan stated they needed to be repositioned two hourly when they were in bed during the day and four hourly at night. On the day time repositioning chart for 20 May 2018 we saw someone had written right and left only . We concluded with one of the nurses this had been written as staff had noted one day that their bottom was sore. However, the night staff had still been repositioning them on to their back dis-regarding this instruction.

In the care file we saw staff were making checks on the air flow mattress to make sure it was set correctly, according to the persons weight. Air flow mattresses reduce the risk of pressure sores but must be configured correctly. The person's weight had been recorded on the chart as being 68.4kgs and the mattress setting recorded on the chart as 120kgs. We showed this to one of the nurses who agreed the documentation was incorrect. They went and checked the mattress and found it was on the correct setting. This meant staff were recording inaccurate information and led us to conclude they did not understand what they were recording. The mattress check charts also required staff to make additional checks on the condition of the mattress. We saw staff had ticked the box to state they had unzipped the cover to check the condition of the mattress. However, this would not have been possible as the specialist mattress did not unzip.

We also reviewed falls risk management within the home. The registered manager had reviewed those at risk of falls. We looked at two people were identified at risk of falls and control measures which included sensor mats and a new wheelchair were in place. Access control was being installed on some doors throughout the premises to further reduce the risk of falls. Falls analysis was conducted by the physio assistant on a monthly basis. We saw examples of how care plans had been updated following falls analysis but this was not consistently the case. For example, one person had experienced recent falls, however their staircase, falls and moving and handling risk assessment documents had not been updated since January 2018. Incident documentation did not always provide sufficient detail of the incident which had taken place and evidence of thorough investigation. For example, the person who had experienced recent falls had on one occasion been found on floor by staff. The person should have had a sensor mat in place. However, the incident description did not detail whether the person's sensor mat had been in place and if it had been effective in alerting staff. We raised this with the manager who reviewed the CCTV surrounding this incident and found the sensor mat had activated and staff had responded rapidly. However, this should have been investigated by the management at the time to determine whether the current plan of care was appropriate to keep the person safe.

Another person had recently fallen out of their wheelchair. Whilst the staff on duty were able to tell us of the control measures now in place providing us with some assurance, their moving and handling plans made no reference to this recent incident and what measures had been taken to prevent a re-occurrence.

We saw another incident, altercation between service users. Although we saw the service had liaised with

safeguarding and the victim and asked if they wanted to take further action, there was no preventative measures documented within the people's care plans.

Another person had been given a food which was not in line with their safe plan of care, increasing the risk of choking. This was not documented on an incident form and therefore it was unclear what the preventative measures were to protect this person and others. Following the inspection, the registered manager sent us assurances regarding how this risk was to be managed.

Where risks had been assessed and best interest decisions held we saw the views of the person and or their representative were not always recorded. For example, we saw a person with capacity had a sensor mat in situ however there was no evidence of discussion with them over this or consent for the equipment. Without fully involving people and their representatives in decisions, a full assessment of the risks and benefits of a particular intervention cannot be made.

We found the provider continued to be in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 regulations.

One of the clinical lead nurses had reviewed all of the care plans, with a specialist nurse; for people who lived with epilepsy.. This ensured all of these specific plans were up to date and detailed actions staff needed to take, for example, in an emergency situation.

The registered manager demonstrated they understood how to report safeguarding concerns to the local authority and Care Quality Commission. Where safeguarding incidents took place, we saw measures were taken, for example disciplinary processes followed in conjunction with the service's HR department. The service had CCTV installed in the communal areas of the home and had used this to help establish the facts in some recent safeguarding concerns.

Since the last inspection we found improvements had been made to nurse staffing levels with three nurses now consistently on duty and clinical leads in place. However, we found people were not always been provided with their contracted one to one support hours to provide them with interaction, stimulation and minimise distress. The registered manager said that due to staff sickness there had been some shortages. For example, we saw one person had only been provided with four hours of one to one support the week commencing the 7 May instead of 28 hours. Daily records of care for some days were very brief with no mention of any social interaction or activity. Another person had only received six hours instead of 14 during the week commencing the 14 May.

This is a breach of regulation 18 of the health and social care act (Regulated Activities 2014) Regulations.

Requires Improvement

Is the service well-led?

Our findings

We did not undertake a full review of all the Key Lines of Enquiry under the Well Led domain, however we examined the management structure of the home and how the home was responding to the management and monitoring of risk.

At the last inspection in January 2018 we identified breaches of regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider sent us an action plan which stated it would be fully compliant with these regulations by 1 June 2018. We undertook this inspection a week before that date in response to concerns raised about the home. However, we would have expected significant improvement since January and instead we identified a number of concerns with risk management processes, demonstrated the improvement plans had not been effective.

We were encouraged that the service now had a complete management structure with the registered manager now supported by three clinical leads and shift managers. We spoke with a clinical lead during the inspection who knew the areas where improvements were needed, which gave us some level of assurance over the future direction of the service. The nursing staff and shift leaders we spoke with were motivated and positive about the home and its future direction. However, at the time of the inspection, we did not find any evidence these appointments had yet positively impacted on nursing and care practice. The provider was also due to implement an electronic care management system following successful implementation at one of its other services. The registered manager told us they were confident this would help them monitor risk better within the service and be more responsive to updating key documents.

At the time of the inspection there was a lack of clinical governance, with no audits of people's care and support or care records taking place. The registered manager told us these had been previously completed by shift leaders. We saw plans were in place for clinical leads to start doing these.

We found a lack of complete and accurate documentation relating to people's care and support. Some examples are as follows: There was a photocopy of a 'Do Not Resuscitate' order in one person's care file. A photocopy is not valid and emergency staff will only act on the original.
It was difficult to establish the dates when two people who were relatively new had been admitted to the home. Care plan documentation was not consistently reviewed on a monthly basis in line with the provider's operating procedures. We also found clinical staff were not on the staff rota therefore it was difficult to establish when they were working.

Due to the lack of appropriate governance systems, lack of appropriate records and ongoing risk within the service we concluded the service was still in breach of Regulation 17 of the Health and Social Care Act 2008(Regulated Activities 2014) Regulations.

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 (1) (2a) (2b) Care and treatment was not always provided in a safe way for service users The service was not always assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance (1) (2a) (2b) Systems or processes were not always established and operated effectively to ensure compliance with the requirements of the regulations. The service was not properly assessing, monitoring and improving the quality and safety of the service provided. The service was not properly assessing, monitoring and mitigating the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not always deployed in order to meet the

Treatment of disease, disorder or injury

requirements of this Part