Fidelia Care Limited

Lypiatt Lodge

Inspection report

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Tel: 01242529707

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19 April 2017

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15 May 2017

Ratings

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on the 19 April 2017. Lypiatt Lodge provides accommodation, nursing and personal care for up to 31 older people. At the time of our inspection there were 18 people living there of whom the majority were living with dementia.

There was 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 undertook this focused inspection on 19 April 2017 to check that they had followed their plan and to confirm that they now met legal requirements in relation to breaches of Regulation 12 and 19. This report only covers our findings in relation to these issues. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lypiatt Lodge on our website at www.cqc.org.uk"

At the unannounced comprehensive inspection of this service on 22 November 2016 breaches of legal requirements were found. After this comprehensive inspection, we asked the provider to take action to make improvements to the administration and management of medicines and this action had been completed. We also asked the provider to take action to make improvements to the recruitment and selection processes for new staff. Although some improvements had been made these had not been sustained.

We have made a recommendation about the management of recruitment and selection records.

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

We found that action had been taken to improve safety in the administration and management of medicines, although further improvements were needed to strengthen the recruitment and selection processes.

We could not improve the rating for safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Lypiatt Lodge

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 focused unannounced inspection on 19 April 2017 was carried out to check that improvements to meet legal requirements planned by the provider after our 22 November 2016 inspection had been made. One inspector inspected the service against one of the five key questions we ask about services: is the service safe? This was because the service was not meeting some legal requirements.

Prior to this inspection we reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law.

As part of this inspection we observed medicines being given to one person. We spoke with the registered manager, the nominated individual and a nurse. We looked at the care records for two people and medicines records. We looked at recruitment records for two new members of staff. Recruitment information was provided after the inspection which had not been available during our visit.

Requires Improvement

Is the service safe?

Our findings

At our inspection of 22 November 2016 we found people's medicines were not administered safely. Medicines had not been given in the correct doses or as prescribed. People's medicine records had not been completed fully to provide staff with the information they needed. The provider sent us an action plan telling us how they would address these issues.

At our focused inspection on 19 April 2017 we found the provider had followed their action plan to meet shortfalls in relation to the requirements of Regulation 12 described above. They had introduced new systems for the administration and management of medicines which were due to be implemented. As part of this they had sought advice from a pharmacist who had advised them on the safe management of medicines in people's rooms. New medicine administration records were being introduced. People who received medicines for a particular medical condition had care plans which described that emergency services would be contacted for additional advice or treatment. The nurse described the action they would take in such a situation. We discussed with the registered manager including more detail in the care records about when emergency services would be called.

People had their medicines at times to suit them and as prescribed. We observed a person having their liquids correctly administered. The liquid had been measured using a syringe to ensure the correct dosage was given. Another medicine had been mixed with water following the administration instructions for this medicine. The nurse confirmed if people managed their own medicines they would make checks to ensure these had been taken as prescribed. No people were currently self-administering their medicines. We found protocols were in place for all people using medicines to be given "when required" such as to treat pain or anxiety. A person had moved into the home four days before our inspection. A medicine administration chart had been completed. Other records such as their individual medicine profile which included a photograph were being prepared.

At our inspection of 22 November 2016 we found people had been placed at risk of being supported by inappropriate staff because robust recruitment procedures had not always been followed. The provider sent us an action plan telling us how they would address these issues.

At our focused inspection on 19 April 2017 we found the provider had not followed their action plan to fully meet shortfalls in relation to the requirements of Regulation 19 described above. Although a new system of checking recruitment information had been put in place this had not been embedded into practice. There were gaps in the employment history for one person. The registered manager recalled discussing this with them but had not recorded the reasons. The applicant had also worked in adult social care previously and the reason for leaving this position had not been verified with their previous employer. This information was acquired after the inspection.

When there had been problems obtaining references other referees had been contacted to supply evidence of the applicant's fitness to work in the home. A satisfactory Disclosure and Barring Service (DBS) check had been obtained prior to new staff starting to work in the home. DBS checks are a way that a provider can

make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

We recommend that the provider, seek advice from an appropriate source, to have a system in place which ensures robust recruitment checks are always completed.