Paydens (Nursing Homes) Limited

Betsy Clara Nursing Home

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 of this service on 13 and 16 September 2016. A breach of legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach.
We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Betsy Clara Nursing Home on our website at www.cqc.org.uk.

Betsy Clara Nursing Home is a care home providing accommodation for up to 50 older people who are living with dementia and who require nursing and personal care. The accommodation is purpose built to care for people who use wheelchairs or have difficulty moving around. The home is located in a residential area in Maidstone, approximately one mile from the town centre. At the time of the inspection 39 people lived at the service.

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.

At our previous inspection on 13 and 16 September 2016, the service was in breach of regulation 12 (Regulated Activities) Regulations 2014. This breach was in relation to effective medicine management. We found that nurses had not always accurately documented when medicines were administered and people living with diabetes did not have guidance in place to manage their blood sugar levels. We also observed poor moving and handling techniques. At this inspection improvements had been made and the service was no longer in breach of the regulation.

Nurses were signing people's medicine records accurately. There were no identifiable gaps in people's medicine records. People living with diabetes had clear guides in their care plans.

Staff received appropriate training for moving handling. During our inspection we observed good moving and handling practices.

The provider had ensured that there were appropriate systems in place to identify and minimise risk for people living at the service. Risks to people's safety had been assessed and actions taken to protect people from the risk of harm.

There was sufficient staff to provide care to people. The provider had effective systems in place to ensure that there was appropriate cover when it was required. Staff had safety checks to ensure they were safe to work with adults.

People were protected from abuse by trained staff who could identify the forms of abuse and who they can report to. The provider had effective safeguarding systems in place.

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

We found that action had been taken to improve safety.

Staff were effectively managing people's medicines.

There were detailed risk assessments in place for those living with diabetes.

Staff received full training on moving and handling.

There were sufficient staff to provide care and effective systems in place to ensure appropriate cover was available.

The provider had ensured there were appropriate measures in place to identify and mitigate risk.

People were protected against abuse as the provider had ensured effective safeguarding policies and procedures.

Betsy Clara Nursing Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Betsy Clara Nursing Home on 14 June 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 13 and 16 June 2016 had been made. The team inspected the service against one of the five questions we ask about services: is the service Safe?

The inspection was undertaken by one inspector and two pharmacist inspectors.

During our inspection we spoke with three people using the service, three relatives, two members of staff, a registered nurse and the registered manager. At this visit, we looked at the auditing and quality assurance records at the service, nine people's care plans, environmental safety documentation and people's medicine records. Before our inspection, we reviewed our previous report and the information we held about the service.

Good

Is the service safe?

Our findings

People we spoke to who use the service told us they felt the care staff provided safe care. One relative told us, "It is completely safe. I have no concerns over safety." Another relative told us, "It is completely safe here. They know how to care for my mum." One person living at the service told us, "I feel safe here."

At our previous inspection 13 and 16 September 2016, the service was in breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We found that nurses had not always accurately documented when medicines were administered and people living with diabetes did not have guidance in place to manage their blood sugar levels. We also observed poor moving and handling techniques during the inspection. At this inspection, the provider had made improvements and was no longer in breach of the regulation.

Medicines were being effectively monitored by trained, competent staff. During a medicine round the nurse took time to engage with people and encouraged them to take their medicines. People were told what their medicines were for and the process was hygienic. The nurse explained that people who were prescribed medicines for diabetes were prioritised and administered their medicines at specific times stated in their care plans. We saw that people living with diabetes had clear guidance on how their diabetes should be managed and people's blood sugar levels were monitored regularly. There were no identifiable gaps in people's medicine records. However, during our observation of a medicine round we saw that a nurse was using thickening powder from a single container for everyone who needed it. The nurse prepared the thickened drinks from an unlabelled decanted cup of thickening powder stored on top of the trolley which could be mistaken for any powdery substance. We reported our concerns to the registered manager who assured us action will be taken.

We recommend the registered manager seek guidance from a reputable source to ensure that all medicine practices are carried out in a completely safe manner.

Some medicines were prescribed to be taken 'when required' (PRN). While most staff were familiar with peoples' needs, there was no visible guidance in place stating how or when these medicines should be given. Variable doses, where people could be administered one or two tablets were also prescribed and some directions on people's records said to be taken as directed. Without guidance the home could not be assured that people received the best outcome from their when required medicines. We reported our concerns to the registered manager and was told, "We are re-writing the PRN guidance following a staff member leaving the service." We saw during our inspection that nursing staff were completing people's PRN records. Following our inspection we were shown evidence to show that this action was completed. All people living at the service had guidance on PRN. The information included the name of medicine, form, route of administration, dosage, minimum time between doses, any special instructions and reason for administration.

All staff had received training on moving and handling. We observed staff assisting people throughout the service and witnessed good moving and handling procedures. People were being supported in line with the

guidance in their care plan. Where wheelchairs were being used people had their feet placed on footplates at all times. All staff we spoke to could tell us individual people's requirements regarding moving and handling.

The provider had ensured that staff were safe to work with the people they supported. We looked at three staff files and these included completed application forms, two references and photo identification. There were no gaps in employment history in the checked staff files. Staff records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure staff were suitable to work with vulnerable adults.

People who use the service told us that there were enough staff working available to support them. One person told us, "There are enough staff here." One relative told us, "There are enough staff; they have time to sit with people living here to have a chat. They never seem rushed." We observed during inspection that there were enough staff to support people at the service. Staff were seen to be responsive to people's needs and reacting quickly to people's call bells. during the day there were 11 care staff on shift and two nurses.

Risks to people's personal safety had been assessed and plans were in place to minimise risk. People had risk assessments that were personalised to their needs and these were reviewed on a regular basis and adjusted if a person's needs had changed. Risk assessments were personalised and provided staff with guidance on how to reduce the risk. Risk assessments included falls, behaviour, skin integrity and breakdown. Those who were living with diabetes had appropriate risk assessments in place that identified appropriate blood sugar levels for each person and what action staff should take if a recording is low. for example, on persons diabetic risk assessment told staff that if the person's sugar level is below fiver, offer a sugary drink and biscuit.

People were protected against the potential risk of abuse as staff had received safeguarding training and could identify the types of abuse and how to appropriately react. All members of staff we spoke with could identify the potential forms of abuse and what they should do with the information. The registered manager had a safeguarding log that identified all historic safeguarding cases and any investigations that were carried out along with notifications to the local safeguarding authority and the care quality commission.