Joseph Rowntree Housing Trust

Lamel Beeches

Inspection report

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Date of inspection visit: 17 and 19 November 2015
Date of publication: 19/01/2016

Ratings

Overall rating for this service

Is the service safe?	Inadequate
Is the service effective?	
Is the service caring?	
Is the service responsive?	
Is the service well-led?	

Overall summary

The inspection took place on the 17 and 19 November 2015. The inspection was unannounced. At the last inspection in March 2015 we identified a breach in Regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regards to the proper and safe management of medicines. The provider had sent us an action plan stating that they would be compliant by 1 April 2015.

In addition, we had also been notified that the unsafe use of bed rails had resulted in a serious incident, which under our powers we were at liberty to investigate. This was a focused inspection to look at specific areas of concern.

This report only covers our findings in relation to those concerns. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Lamel Beeches on our website at www.cqc.org.uk.

Lamel Beeches provides care and support to 41 people. It is part of The Joseph Rowntree Housing Trust. Lamel Beeches is situated on the west side of York with an elevated position overlooking the city, with its major transport links. It is set in well maintained, mature gardens, has car parking on site and has lift access to both floors.

Lamel Beeches had a registered manager who was on a phased return to work. In the interim they also had an acting manager. A registered manager is a person who

Summary of findings

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 that the registered provider had failed to ensure the proper and safe management of medicines. Medication was not being given as prescribed by the GP and there was not always sufficient stock available. Some items of medication were out of date and audits which were being completed by management did not always result in the appropriate action being taken.

We found that the registered provider had failed to ensure that equipment such as bed rails were being safely used. Risk assessments were not suitable or sufficient; actions required to ensure bed rails were used safely had not always been completed. Staff had not received training in their use. This increased the risk of harm to people.

Staff were aware of the different types of abuse and were clear of reporting procedures. We saw that checks on the environment were carried out and maintenance certificates viewed during our visit were up to date.

People told us that they had to wait a long time before call bells were responded to. The registered provider told us that they were trying to recruit additional staff. We found the registered provider had used agency staff to help provide sufficient cover at the home.

Staff were recruited safely and relevant recruitment checks were completed before they started work.

The home was clean and smelt pleasant when we visited.

We identified a continued breach of Regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of the report. We also identified a breach of Regulation 12(1) and 12(2) as Care and treatment was not provided in a safe way for service users. We are still considering our enforcement powers in relation to this breach and we will report on this in future inspections of the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Equipment, for example bed rails, were not safely managed. Risk assessments were not always up to date and where remedial actions had been identified these were not always actioned. This increased the risk of harm to people.

People did not always receive their medication safely and as prescribed by their GP. Medication was not always available in sufficient quantities and staff were not keeping accurate records of medicines administered.

Inadequate

Is the service effective?
Not rated

Is the service caring?
Not rated

Is the service responsive?
Not rated

Is the service well-led?
Not rated

Lamel Beeches

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 and to look at the overall quality of the service.

This inspection took place on 17 and 19 November 2015 and was unannounced. The inspection was undertaken by two Adult Social Care (ASC) inspectors on the first day and one ASC inspector on the second day. This was a focused inspection to look at specific areas of concern.

We did not request a provider information return (PIR) on this occasion as the visit was carried out at short notice. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make

On the day of the inspection we spoke with five people who lived at the home, two members of staff, the acting manager, the regional manager, the quality manager, health and safety manager and the registered provider. We checked the care records for 11 people who lived at the home, accident / incident records, quality monitoring records and environmental risk assessments. We also toured the premises to assess safety and cleanliness.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. Comments included "I feel safe – yes" and "I feel safe here." A staff member said "In terms of safety we do the best we can."

During our last inspection we found that improvements were required to the safe administration of medicines. After this inspection, the provider wrote to us to say what action they would take to meet the legal requirements. This was a follow up visit to check that the actions recorded in the provider's action plan submitted in May 2015 had been met.

We found that the registered provider had failed to ensure the proper and safe management of medicines. This is a continued breach of Regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at medication records for twelve people. We found that there were still a high number of missed signatures on medication administration record (MAR) charts. This meant there was no clear record to confirm whether a person had received their medication and also meant that medication may not have been given as prescribed by the GP. We found that some medication was out of stock which meant that it was not available in sufficient quantities.

Each person had a medication cabinet in their own room where their medicines were stored. We observed a nurse carrying out part of the medication round. All medication was administered by the nurse on duty. Medication risk assessments were completed to identify the level of support required and to help keep people safe. The nurse had a list of medicines required by each individual which was ticked off as medicines were administered.

The dressings file, used to record any dressings which people required was difficult to navigate and it was not always clear what was being given and what had been discontinued. There were items for example, creams which had been prescribed as directed without specific instruction as to how staff should safely administer the medication. This meant that there was an increased possibility of an error occurring.

We saw that eye drops and creams which had a set shelf life had not been disposed of when they had passed the use by date.

We saw that controlled drugs were secured safely and records were maintained. Controlled drugs (CD's) are medicines which are controlled under the Misuse of Drugs legislation. Checks were carried out on these medicines to ensure that the correct amounts were held.

We looked at the management report which had been carried out by the acting manager to audit medication. We saw that twenty five medication administration records had been analysed. Of these we saw that there were anomalies in twenty one of the twenty five MAR charts. We saw that there were forty three missed signatures in MAR charts. Of those there were twenty four possible doses of non-administered medication, which meant that there was the potential that people were not receiving their medication as prescribed by their doctor.

Although audits of medication were completed by management; these did not record what actions had been taken in response to concerns identified. The deputy manager told us that additional supervisions were being held and a meeting was being held for all nurses to discuss the failures.

Staff told us that they had received safeguarding vulnerable adults and whistleblowing training. They told us that they could raise issues of concern. They understood the different types of abuse and were clear of how and who to report any concerns to.

We looked at the way risks were managed. We saw that checks were carried out on the environment. We looked at a sample of these checks, which included electrical and gas safety, thermostatic valves, hoist checks and fire safety checks. All of these checks were up to date.

We also looked at checks which were carried out to help minimise risks to individual people. These included checks on bed rails and bed rail assessments. We requested care files for all people who had bed rails in use at the home. We looked at the bed rail assessments for these eleven people.

We found that for one person there had been a delay in completing the bed rail assessment, which meant that risks may not have been identified at an early opportunity.

Inadequate

Is the service safe?

Although risk assessments were in place, they were not suitable or sufficient as where risks were being identified, the provider was not recording what action had been taken to minimise the risks to people.

There was no evidence that staff had received sufficient training in the safe use of bedrails which meant that they may not be able to carry out suitable checks to ensure they were safe. This meant that people were at risk.

The acting manager told us that 4 sets of new bedrails had been fitted. They told us that expansion rails had been fitted. They told us that checks were not being carried out on bed rails to check that they were fitted correctly and safely maintained. We were told that new documentation was being introduced. As we had identified that people may be at risk we agreed for some immediate actions to be carried out. This included updating the risk assessments and making sure that the bed rails were safe and suitable, as well as providing training to staff so that at least one staff member on each shift had been trained in bed rail safety. We are considering our enforcement powers in this area and will report further if action is taken.

This was a breach of Regulation 12(1) and 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as Care and treatment was not provided in a safe way for service users.

We looked at staffing levels across the home. We looked at rotas and spoke with staff. The home was experiencing difficulties recruiting staff so some agency hours were being used. We were told that a total of 97.5 agency nurse hours had been used during the day and10 agency nurse hours at night. In addition, the registered providers had used 77 care worker agency hours during the day and 100 care worker agency hours at night during the three weeks prior to us visiting. The management and staff said that, where possible, regular agency staff were used and this was confirmed by staff. This provided some continuity in care for people using the service.

People provided mixed feedback in relation to staffing numbers. One person said “I ring the bell, staff come eventually.” Another person said “Could do with a few more staff. I wear a neck pendent and staff answer buzzer quickly.” A further person said “I ring the bell it takes a long time for staff to come. We are told someone is coming but then we have to wait.”

Staff also made the following comments “Staffing levels mean that sometimes we are pushed. A lot of agency at present.” And “The regular agency staff are good. If we have full staff it’s ok. We can spend more time telling new agency staff what to do. Staffing has been an issue for a long time.” Staff also commented that due to the handover time at night, the floor was left unsupervised. The registered provider agreed to amend staff working hours so that this could be addressed.

We looked at the recruitment files for four staff. We found that the appropriate recruitment checks were completed. We saw that application forms were completed, interviews held and that two employment references and Disclosure and Barring Service (DBS) first checks had been obtained before people started to work at the service. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. This information helped to ensure that only people considered suitable to work with vulnerable people had been employed.

We looked at infection control. The home was clean and smelt pleasant throughout. Domestic staff were employed and we observed staff using personal protective equipment (PPE) during our visit.

Is the service effective?

Our findings

N/A

Is the service caring?

Our findings

N/A

Is the service responsive?

Our findings

N/A

Is the service well-led?

Our findings

N/A

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

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 We found that the registered provider had failed to ensure the proper and safe management of medicines. This was a continued breach of Regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We issued a warning notice.