Priory Elderly Care Limited

Atkinson Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection of this service on the 15 October 2014 at which two breaches of the legal requirements were found. This was in relation to, management of medicines and there were not always sufficient staff to keep people safe.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook a focused inspection on the 4 June 2015 to check they had followed their plan and to confirm they now met legal requirements.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for "Atkinson Court" on our website at www.cqc.org.uk

Atkinson Court Care Home is registered to provide accommodation and nursing care for 75 people who may also have a dementia related condition. Atkinson Court Care Home has 10 Intermediate Care beds which are for people who have been discharged from hospital but who still require support prior to returning home. There were 59 people living at the home at the time of our inspection.

The home had a peripatetic manager who has worked in this role since February 2015. This person is not registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

At our focused inspection on the 4 June 2015, we found the provider had followed their plan which they had told us they would and legal requirements had been met.

Summary of findings

People who used the service told us they were happy living at the home and they felt safe. We looked at the arrangements in place for the storage, administration, ordering and disposal of medicines and found these to be safe. Medicines were administered to people by qualified nurses.

We found people were cared for, or supported by suitably qualified, skilled and experienced staff. Recruitment and selection were taking place and appropriate checks had been undertaken before staff began work.

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?

We found that action had been taken to improve the safety of the service.

We found the home had arrangements in place which ensured people's medicines were managed safely.

There were sufficient numbers of staff on duty to ensure people's safety. However this had not always been the case.

The provider was now meeting legal requirements.

While improvements has been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for safe at the next comprehensive inspection.

Requires improvement

Atkinson Court Care 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.

We undertook a focused inspection of Atkinson Court on 4 June 2015. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 15 October 2014 had been made. We inspected the service against one of the five questions we ask about services: Is the service safe? This is because the service was not meeting legal requirements in relation to that question.

This inspection was undertaken unannounced by one inspector. At the time of our inspection there were 59 people living at Atkinson Court.

Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements.

At the visit to the home we spoke with 11 people who lived there, seven visitors, the peripatetic manager, three nurses and eight care staff.

At the visit we looked at documents and records that related to people's medication, three months staff duty rotas, staff allocation sheets and staff meeting minutes.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Atkinson Court on 15 October 2014, we found the recording of controlled drugs was incorrect and staffing level required improvement.

This was a breach of Regulation 12(g) (In safe care and treatment) and Regulation 18(1) (In staffing) Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our focused inspection 4 June 2015, we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 12 and Regulation 18 described above.

We looked at the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock levels and other records for nine people.

All medicines were administered by qualified nurses. We observed part of the lunch time medicines round on two units. The medicines administration records were completed at the time of administration to each person, helping to ensure their accuracy. Written individual information was in place about the use of 'when required' medicines to assist staff in their decision making when administering medicines. Protocols were in place for the safe administration of medicines via a PEG (Percutaneous endoscopic gastrostomy) tube, when necessary.

Staff administering medicines were aware that some people had medicines that should be given at certain times such as, 'before food'. Clear records of GP advice were made when new medicines were prescribed and these were promptly started.

We inspected medication storage and administration procedures in the home. We found that storage cupboards were secure, clean and well organised. We saw that the drug refrigerator and controlled drugs cupboards provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use. Drug refrigerator and room temperatures were checked and recorded to ensure medicines were being stored at the required temperatures

Some prescription medicines contain drug that are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines. We saw that controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained nurses.

Creams and ointments were prescribed and dispensed on an individual basis. The creams and ointments were properly stored and dated upon opening. All medication was found to be in date.

We saw some prescribed medicines had to be given in a precise manner. For example, some medicines were prescribed to be given before food. We saw the prescriber's requirements were being met. We saw all as necessary (PRN) medicines were supported by written instructions which described situations and presentations where PRN medicines could be given.

We looked at the medication administration records (MAR) sheets these was complete, however contained the odd gaps in signatures. The manager was aware of this and taken action, for example discussion was held with staff. We saw that any known allergies were recorded on the MAR sheet.

The records about medicines were generally clear and showed that people had been given the medicines they were prescribed. The home's records now show medication been given at the correct times with regard to meals and food. The staff administering medicines told us that the medicines had been given safely and according to the manufacturers' directions. The nurses showed a good understanding about the different times medicines should be given.

The manager explained that various checks were made to ensure medicines were handled safely and that when failings were found they were addressed with the staff quickly to ensure they were learnt from and not repeated in the future.

We looked at the way staffing levels were determined at the home and found at times the home had not always had the required number of nurses on duty. In the action plan sent to us by the provider they stated the staffing levels had been adjusted on the second floor so that there were two nurses on duty each morning. However this had not always taken place because of sickness and recruitment. The manager told us the home had recruited four nurses and they were awaiting Disclosure Barring Service (DBS) checks.

Requires improvement

Is the service safe?

The DBS is a national agency that holds information about criminal records. These checks helped the provider to make sure job applicants were suitable to work with vulnerable people. We saw evidence of this.

We found staffing levels were sufficient to meet the needs of people using the service on the day of our visit. However, not all the people who lived at the home and their relatives felt there was sufficient staff to provide the care services that they required. One person said, "I'm paying good money there are times when I have to wait half an hour for someone to come and attend to my needs." When we asked if the call bells were answered promptly we were told by the person it was not especially on a night.

Throughout the day we observed staff responding to people's call in a timely manner. We spoke with other people in the home about response to calls. They told us, "They always come when I call in good time." "Sometimes it feels long but they have others to look after." "I haven't taken much notice." "Some would say so, but I don't mind."

We had a discussion with the manager who told us they think people don't have to wait long for assistant. They also told us a call bell time monitor/print out system has been ordered by the home in order to better manage the response to call bells.

In discussion with service user relatives we were told, "Some carers have terrible attitudes. They don't acknowledge you being here when they come into work. Some carers are lovely and will do anything for you if you ask." Another said, "Some staff can be narky and I have heard some raise their voices at people. This was discussed with the manager who told us this would be looked at during training and supervisions.