South Yorkshire Housing Association Limited

Birch Avenue

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 5 August 2014. During this inspection we identified a breach of legal requirements relating to the safe use of equipment. Lifting equipment is serviced and tested under the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) and should be serviced every six months. We identified that equipment had not been serviced within the above timescale.

We looked at a number of hoist slings and found that some labels were worn and the information that should be legible was illegible or not easy to read. Slings should be taken out of circulation if this information is not clear. The provider's moving and handling policy stated that slings are subject to LOLER testing. We could not find any evidence that this had been carried out.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to the breach. We undertook a focussed inspection on 7 April 2015 to check that they had followed their plan and to confirm that they now met legal requirements.

The following report only covers our findings in relation to this topic. You can read the report form our last comprehensive inspection by selecting the 'all reports' link for 'Birch Avenue' on our website at www.cqc.org.uk.

Birch Avenue provides accommodation and nursing care for up to 40 people living with dementia. There were 34 people living at Birch Avenue at the time of this focussed inspection.

A registered manager was in place. A registered manager is a person who has registered with CQC to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

Our focussed inspection of 7 April 2015 identified that the provider had not followed the plan which they had told us would be completed by 31 March 2015. This meant that Birch Avenue continued to be in breach of legal requirements.

We examined eight hoist slings and found that information which should be legible continued to be illegible or not easy to read on three of the eight slings. Slings had not been tested in accordance with the LOLOER Regulations and the provider's own moving and handling policy. The lack of this key check placed people at risk of unsafe care and treatment.

The registered manager informed us that sling checks were implemented following the last inspection. We identified that these checks were not undertaken in two of the four bungalows. There were gaps in the sling check sheets of the two bungalows where the form was in place.

The provider's action plan stated, 'All care plans will include what size of sling each resident uses and which loop should be used.' One care plan contained information about the size of sling and hoist required. It did not contain any information about the positioning of hoist loops. Information about the size of sling to be used or the positioning of the sling loops was not present in the three remaining care plans.

We could not review training records to verify that the moving and handling training shortfalls identified during our last inspection had been addressed. This was because the clinical manager who was responsible for this area of practice was on leave at the time of our inspection. The registered manager could not access these records and agreed to forward them on the clinical manager's return from leave. This information was not provided.

Our inspection identified a continued beach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this report.

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.

We found that action had not been taken to improve the safety of the service and ensure that the service was now meeting legal requirements.Whilst hoists had been serviced, checks of the slings used to lift people had not been undertaken to ensure they were safe for use.

We identified a number of shortfalls within people's records which placed people at risk of unsafe care and treatment. The care plans of people who required hoisting had not been updated to include information about the type of sling and position of loops to ensure they were moved safely. Some of the systems and audits relating to equipment were ineffective.

The lack of training records on the day of our inspection and following our visit meant that we were unable to verify that the moving and handling shortfalls identified during our previous inspection had been addressed.

Requires improvement

Birch Avenue

Detailed findings

Background to this inspection

We carried out this inspection under section 60 of the Health and Social Care Act 2014 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014.

This focussed inspection of Birch Avenue was undertaken on 7 April 2015. The inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection of 5 August 2014. The inspection was focussed against our key question: if the service safe? This is because the service was not meeting legal requirements in relation to this question at the time of our last inspection.

The inspection was undertaken by an adult social care inspector.

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.

During our inspection visit we spoke with the registered manager, deputy clinical manager, two nurses and two support workers. We also used the Short Observations Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also undertook some informal observations. Our observations focussed upon the care and support people received to move within the home.

We reviewed a range of records during our inspection visit. These included the paper and electronic care plans for four people who required support to move, daily records of people's care and treatment, policies, procedures and quality assurance documents.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Birch Avenue in August 2014 we found that equipment was not always safely maintained and fit for purpose. For example, we found that hoist labels were worn and information that must be legible was illegible or not easy to read. Slings should be taken out of circulation if this information is not clear. The care plans of people who required hoisting did not include information about the type of sling and position of loops to ensure they were assisted to move safely.

All staff had received moving and handling refresher training within the past year; however, nine members of staff had not received the more in-depth practical skills course since 2010 and ten members of staff had never received this training. We were concerned that this may mean that staff were not aware of up to date techniques and ways to safely support people to move.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection our observations and our review of equipment records demonstrated that six monthly visits from external contractors had taken place in order to ensure that most of the mechanical equipment in place at Birch Avenue was properly maintained and serviced. We did however note that the record documenting the provider's recent health and safety quality assurance visit of 17 March 2015 stated that profiling beds had not been serviced for over a year. The quality assurance document noted the need for this shortfall to be addressed as soon as possible.

We looked at eight hoists slings. The information which should be legible continued to be illegible or not easy to read on three of the eight slings checked. Slings should be serviced and tested in accordance with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) and the provider's own moving and handling policy. There was no evidence that this check had been undertaken and a record of the provider's recent health and safety quality assurance visit stated that LOLER examination certificates were not in place for slings. The lack of this key check placed people at risk of unsafe care and treatment.

The registered manager informed us that sling checks were implemented following the last inspection. Our review of records and our conversations with staff and the registered manager demonstrated that these checks were not in place in two of the bungalows. In the bungalows where the checks where in use, there were gaps in the records. This evidenced that the checks were not undertaken each time the slings were used and, as stipulated on the provider's 'hoist sling check form.' Additionally, the lack of an identifier on each sling meant that the check did not ensure a systematic check of all the slings within the home.

The provider's action plan stated 'All care plans will include what size of sling each resident uses and which loop should be used. These will be monitored via care plan audits.' The deputy clinical manager informed us that this information was now within people's care plans and was considered when care plans were audited.

We asked a permanent member of staff about the size of sling and position of loops needed to move one person. They told us that they would use, "A large sling, not sure which loops are used. I'd try the shortest or the blue. Just been told to make them even." When asked if people's care plans contained information about the equipment people needed to safely move, the same member of staff stated, "I don't know, I've not had chance to look at the care plans." Staff spoken with during our inspection told us that they knew how to support people to move as a result of working at the home previously and observing the equipment used by their colleagues.

We checked the paper and electronic care plans of four people who required support to move. There was information about the hoist and size of sling needed within one person's care plan. No information was documented about where the loops should be positioned to ensure the person was safely supported. None of the remaining care plans contained information about the type of hoist, size of sling, or which loop the sling should be placed on. The information within people's care plans about the support they needed to move was general. For example, one person's care plan stated, "Staff are to use sling and hoist to transfer," another person's plan stated, "I need two staff to help me transfer using the hoist/ sling."

Whilst there was no evidence to suggest the above issues had negatively impacted upon people, the absence of key information meant people were not protected against the risks of receiving inappropriate care and treatment. The registered manager informed us that agency staff and the providers own flexible staffing pool were being used to

Requires improvement

Is the service safe?

cover six vacant nurse posts at the time of our inspection. The lack of this key information meant there was a risk that agency and new members of staff may be unfamiliar with key information about how to safely move and handle people.

We requested the tool used to review people's care plans. The clinical deputy manager brought us the audits a colleague had undertaken for two of the bungalows. The audits the clinical deputy had undertaken for the remaining two bungalows were not provided and could not be found by the registered manager following the clinical deputy finishing their shift. The tool used was ineffective. It was a tick list of areas required within each care plan and did not contain any detail about the information which should be within people's moving and handling care plans, or plans covering other areas of care.

Staff spoken with during our inspection said they had received moving and handling training. The registered manager was unsure if the training shortfalls identified during our comprehensive inspection had been addressed. She informed us that the clinical manager was responsible for this area of practice. The clinical manager was on leave at the time of our inspection and the registered manager was unable to access the required records. The registered manager agreed to forward the information once the clinical manager had returned from leave. This information was not provided and meant that we could not verify that the shortfalls had been addressed and that all staff were aware of up to date techniques and ways to safely support people to move.

The clinical deputy manager informed us that 'resident observations sheets 'were in place on each bungalow to record when people who were non mobile were supported to change position in order to maintain good blood flow and reduce the risk of skin damage. We were informed that this document recorded the differing types of support provided to people and that this therefore indicated a change of position. For example, the clinical deputy manager said that the time someone was supported to use the toilet would be recorded on the form and would therefore also indicate a change of position.

We reviewed the resident observation sheets in place on each bungalow for the seven days prior to our inspection and found numerous shortfalls. Whilst the hourly night observations within these records had been completed for each record reviewed; there were a number of gaps within individual days as well as a total absence of recording for some days. For example, no day time recordings had been completed for the first, sixth and seventh of April 2015 for bungalow three. The lack of these key recordings meant that meant that people were at risk of unsafe care and treatment. The registered manager agreed with our findings and told us of their intention to identify the staff that had been on duty on the days in question and to talk to them and all staff about the importance of ensuring accurate, hourly records of the support provided to people.

Our inspection identified a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our observations and conversations with staff evidenced that the staff on duty were aware of the equipment used by each person. We observed staff supporting people to move and overheard two members of care staff support one person to move using a mobile hoist. The staff using the hoist clearly explained each step of the process and supported the person at their own pace.

A range of equipment was in place to meet the needs of people living at Birch Avenue. We saw that a number of different hoists were in place to support people to transfer from one place to another. We also noted that suitable equipment was in place in people's en-suite shower rooms and the bathrooms within each bungalow to support people with their personal care needs. We looked at wheelchairs, hoists and pieces of bathing equipment in each of the four bungalows. Each item was clean, was in good condition and was fit for purpose.

Staff told us that equipment within the home was well maintained and that there were always sufficient slings and hoists. Staff were able to explain how they maintained people's dignity and privacy, as well as how they minimised the risk of the spread of infection when using pieces of equipment.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Suitable arrangements were not in place to ensure that care and treatment provided to service users who required support to move was safe by : a)Assessing the risks to the health and safety of service users of receiving the care or treatment. b)Doing all that is reasonably practicable to mitigate any such risks. e)Ensuring that the equipment used by the service provider for providing care or treatment to a service users is safe for such use and is used in a safe way.

The enforcement action we took:
We have served a warning notice to be met by 15 June 2015.