

Brighterkind Health Care Group Limited

Ivybank House Care Home

Inspection report

Ivybank House
Ivybank Park
Bath
Somerset
BA2 5NF

Date of inspection visit:
08 July 2017

Date of publication:
05 October 2017

Tel: 01225837776

Website: www.brighterkind.com/ivybankhouse

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on 8 July 2017 and was unannounced.

We carried out an unannounced comprehensive inspection of this service on 01 March 2017. The service was rated 'Requires Improvement'. Four breaches of legal requirements were found. One breach related to safe care and treatment. After the comprehensive inspection, we used our enforcement powers and served a Warning Notice on the provider for this breach on 7 April 2017. This was a formal notice which required the provider to meet the legal requirements by 5 May 2017. Following 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 this focused inspection to follow up the breach detailed in the Warning Notice and to confirm that they now met legal requirements. This report only covers our findings in relation to this legal requirement.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ivybank House Care Home on our website at www.cqc.org.uk"

Ivybank House Care Home is registered to provide accommodation and personal care for up to 43 people. At the time of our inspection there were 34 people living at the service.

There is 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.

Medicines were not managed safely. Some records contained conflicting information about medicines people were allergic too. Medicines were not always stored safely.

Risks to people were not always managed safely. Risk assessments were not always updated when required. People's records showed they were not repositioned in line with their care plans. One person was not supported to drink amounts identified as appropriate for them. People were not weighed in line with their identified needs.

Staff received training in safeguarding vulnerable people, but did not fully understand their responsibilities around reporting abuse.

People told us there were sufficient staff to meet their needs.

There were suitable recruitment procedures and required employment checks were undertaken before staff began to work at the home.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 always safe.

People could not always expect to receive their medicines as they had been prescribed because management of medicines was not always safe.

People's risks were not always managed safely. Risk assessments were not always updated when required.

People were supported by staff who did not fully understand their responsibilities around reporting abuse.

People told us there were appropriate staffing levels to meet their needs.

Requires Improvement ●

Ivybank House 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 an unannounced focused inspection of Ivybank House Care Home on 8 July 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 01 March 2017 comprehensive inspection had been made. The team 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 some legal requirements.

The provider was not asked to complete a Provider Information Return (PIR). This 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. Instead, we reviewed all of the information we held about the home, including the provider's action plan following the last inspection and notifications of incidents that the provider had sent us.

During the inspection we spoke with three people who used the service, four staff and the deputy manager. We looked at medicines records, three care plans and associated documents and four staff files. We also looked at records that related to how the home was managed such as training records and medicines audits. We observed care and support in communal areas, spoke with three people in private and looked at the care records for five people. After the inspection we spoke with the registered manager and regional manager.

Is the service safe?

Our findings

At our previous two inspections, in March 2017 and January 2016 we found that medicines were not always managed safely and people's risk assessments were not always updated. After the March 2017 inspection we served a Warning Notice which required the provider make improvements by 5 May 2017. We found some, but not all of the required improvements had been made.

Poor management of medicines placed people at risk. Information in one person's Medicine Administration Record (MAR) conflicted with the information in their medicines care plan. Their MAR identified three medicines they were allergic to and another two medicines they were resistant to. This information was not all available in the person's care plan. There were several gaps in MAR charts. 'Sign me' stickers had been used to highlight some of the gaps where staff should sign, however these shortfalls had not been followed up.

Medicines were not always stored safely. Fridge and room temperatures had not been recorded daily to ensure the optimal storage of medicines, such as those used for diabetes. Temperatures of the room were supposed to be recorded daily and fridge temperatures were supposed to be recorded twice daily. There were significant gaps in both fridge and room temperature records. This meant the registered manager could not guarantee medicines had been stored in line with good practice, and medicines may not be as effective.

Topical medicine records (TMARs) were in place, but they had not in all cases been consistently signed by staff to indicate that people had their lotions and creams applied as prescribed. In some cases the instructions were not clear. For example, one person required a barrier cream to be applied twice daily. There were only three days in June 2017 when this cream had been applied as prescribed, and one day in July 2017. There was no guidance as to where on the person's body the cream should be applied.

In one person's room we found three boxes of identical creams, none of which had been marked with a date of opening. This meant it was impossible to be sure which one was being used. Other creams did not have the date of opening marked on them, although the deputy manager said there should have been. Marking creams with the date they were opened is good practice to ensure medicines are discarded at the point in time when the cream is no longer considered effective.

Risk assessments did not help ensure that people were cared for safely. One person's risk assessment said to review long term falls risk assessment monthly; however there was an eight month gap between August 2016 and June 2017. Another person suffered two falls in January, however they had not been referred to the falls team. This person told us they had fallen three weeks ago as well, and had suffered a serious injury. They said, "I had another fall and I'm in pain, I have patches with medicines for the pain." The person's falls risk assessment had not been revisited when the person had fallen to check it remained effective. We discussed this with the deputy manager who said they would have expected these people to have been referred to the falls team. This meant people were not being protected against risks and action had not been taken to prevent the potential of harm.

One person had a large jug of squash available, but they told us they couldn't lift it. They said, "I can't use it because it tips over." This person's care plan said their fluid intake should be monitored. In July 2017 there had been four days when the person had not had enough to drink, according to the amount that had been identified as appropriate for them. Staff had failed to report this during handover meetings so the person could receive appropriate care and support. This meant the person was at risk of dehydration.

Staff had not consistently protected people against the risk of poor or inappropriate care. One person told us, "I'm not very good, I'm in agony sat in this stupid chair" and "I've got a sore area at the bottom of my spine, staff cream it for me." One person's risk assessment noted they had a pressure ulcer and required two hourly repositioning. Their records showed they were not always repositioned in line with this guidance.

A person's monthly review said they were to be weighed weekly, this was not being done. There were no records of the person being weighed between November 2016 and June 2017. Another person's care plan also noted they should be weighed weekly; however this had not been done although the person was clearly losing weight.

Staff did not have guidance about two people who needed to avoid cranberry juice. Cranberry juice can interact with some medicines and should be avoided, for example if people are taking anti-coagulant medicines. Cranberry juice was freely available in the dining room. Staff said they did not know people taking anti-coagulants should avoid cranberry juice. This meant people's medicines were not always managed and administered safely.

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

Where people took medicines which slowed the heart rate, staff were monitoring to ensure the medicine was not given to people if their heart rate was slow; this was in line with correct procedures.

After the inspection, we spoke with the regional manager. They told us of several changes that were being implemented following our inspection. These included changing how audits were conducted and changing the audit forms, providing more training for staff and reviewing people who may need to be referred to specialists. Other changes included making changes to handover meetings so that anyone with any changing needs would be followed up. The regional manager acknowledged this was a reactive response, but explained they had been planning changes before the inspection. The regional manager told us they would be at the home one day a week to provide support for the registered manager. A GP visited the home regularly and the regional manager said staff were able to raise any concerns with them.

Staff told us, and records seen confirmed that all staff received training in how to recognise and report abuse. However, although staff had a clear understanding of different types of abuse, staff did not understand their responsibilities around reporting. Staff said, "I'd ask them questions and if they said they're hurt or I think it's serious I'd report it to a senior or the registered manager" and "It's the manager's discretion if it gets reported to safeguarding or not." Staff told us they were clear about the whistleblowing policy and said they would escalate any concerns to the regional manager if necessary. We discussed this with the deputy manager who said the training had been quite clear around expectations of staff for reporting.

On the day of the inspection staff told us they were three staff short. The deputy manager came in to cover this. However, people told us there were usually sufficient staff to meet their needs. One person said, "They're very good staff", "We've got to wait when they're busy" and "They're short staffed today." We

observed lunch in the dining room and saw there were enough staff to assist people appropriately. We asked the registered manager to send us staff rotas for the previous two weeks, however we never received these.

Recruitment records showed that appropriate checks had been completed to ensure staff were suitable to work with vulnerable people. Staff personnel files contained copies of their application form, documents proving their identity and eligibility to work in the UK, their terms and conditions of their employment, two satisfactory references and confirmation that a satisfactory disclosure and barring service (DBS) check had been received. The DBS checks people's criminal record history and their suitability to work with vulnerable. A health questionnaire and declaration were also obtained. One file had gaps in employment which had not been explored during interview. Exploring gaps in employment is important to ensure potential staff are suitable people to work with vulnerable people. The registered manager provided this information after the inspection. This meant that there were effective recruitment and selection processes in place.