Bluebell Place Limited

Bluebell Nursing & Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 29 and 30 April 2015. Following our inspection we were notified of incidents in which we reviewed and judged to be of concern. One person had sustained a bone fracture following a fall. Additionally, we received information of concern from an external agency. The external agency advised that unexplained bruising had been found for one person. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those areas. You can read the report rom our last comprehensive inspection, by selecting the 'all reports' link for Bluebell Nursing and Residential Home on our website at www.cqc.org.uk

Bluebell Nursing and Residential Home provides accommodation and personal care for up to 80 people who require nursing care and people living with dementia. The service is situated over three floors and includes a residential unit on the ground floor, a nursing unit on the middle floor and a dementia unit on the top floor.

A registered manager was 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.

Although suitable arrangements were in place to manage the majority of identified risks, improvements were required in relation to the pressure mattress settings so as to ensure that these were aligned to people's weight.

Improvements were required to show that the provider's own quality assurance systems effectively analysed and evaluated information so as to identify where quality or safety for people using the service was compromised and to drive improvement. The management team were not aware that several members of staff had not received up-to-date manual handling training or training relating to the management and prevention of falls.

The service managed incidents and accidents well in an open, transparent and objective way. There was no evidence to suggest that where incidents and/or accidents had occurred, all appropriate steps had not been taken to try and safeguard people for their health and wellbeing. Although there were some occasions whereby staffing levels were not maintained, there was no evidence to show that this impacted on the safety of people using the service nor did reduced staffing levels correlate with any significant incidents or accidents.

Where people could become anxious or distressed staff supported them to manage their behaviour and care plans provided appropriate guidance for staff to follow to ensure theirs and other's safety and wellbeing.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was safe.

Although steps were in place to safeguard and manage risk, improvements were required to ensure that the setting of people's relieving mattresses were set correctly in relation to their weight.

Although staffing levels as told to us were not always maintained, there was no evidence to show that this had a negative impact on people using the service.

Where people may become anxious or distressed, staff manage the situation in a positive way and seek to understand and reduce the causes of behaviour that distress others of place them at risk of harm.

Is the service effective?

Requires Improvement

The service was not always effective.

Although the management team are aware that staff working at the service require training in key areas, they had not ensured that manual handling training for staff had been up-to-date or provided falls management training.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Improvements were required to show that the provider's own quality assurance systems effectively analysed and evaluated information so as to identify where quality or safety for people using the service was compromised.

Bluebell Nursing & Residential 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.

This inspection took place on 27 June 2016 and was unannounced.

The inspection team consisted of one inspector.

We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

We spoke with five people who used the service, one relative, five members of staff and the registered manager.

We reviewed seven people's care plans and care records. We looked at 12 staff support record, particularly in relation to their training information. We also looked at the service's arrangements for the management of quality monitoring and audit information.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection a statutory notification was sent to the Care Quality Commission advising that a person who used the service had sustained a bone fracture whilst using an item of equipment to transfer from one place to another. Statutory notifications include information about important events which the provider and registered manager are required to send us by law.

The registered manager was able to demonstrate to us that steps to safeguard the health and safety of the person using the service were in place at the time of the above incident. Prior to the incident appropriate appointments had been made to external health care services as staff had noted that the person had a swollen and painful knee. There was no evidence to show that prior to the above incident concerns were identified when the person was supported by staff to transfer them from one place to another using an item of equipment. Consequently, documentation had been revised following the incident, taking into account the injury sustained and a change in the person's circumstances, including their ability to mobilise. Records relating to the person's anxious and distressed behaviours demonstrated that between March 2016 and June 2016, the person could be resistant when using an item of equipment to transfer from one place to another. However, although a risk assessment was completed in relation to the person's manual handling care and support needs, it did not include specific manual handling constraints identified for this person as detailed above. This was discussed with the registered manager at the time and they provided an assurance that this information would be included. Equipment used to transfer people from one place to another was well maintained and observations of staff practice showed that staff used the equipment correctly.

Additionally, we checked the setting of the above person's pressure relieving mattress that was in place to help prevent pressure ulcers developing or deteriorating further. We found that their pressure mattress was not correctly set in relation to the person's weight. The pressure mattress was set on 'Active 3' for a person weighing between 46 and 80 kilgrams and yet the person's weight was 37.2 kilograms. Another person's pressure mattress was also set on 'Active 3' and this also showed that it was incorrectly set according to the person's weight. Although at the time of the inspection neither person had pressure ulcers, there was a potential risk that if consistently set on the wrong setting the equipment would not be as effective as it should to help prevent pressure ulcers developing or deteriorating further . This was discussed with the registered manager and other senior members of staff at the time of the inspection. An assurance was provided that all pressure mattresses would be checked to ensure that these were set correctly for the future.

Evidence viewed showed that the management team had identified those people at risk of falls and put in place suitable interventions to control, mitigate and reduce these for the future. Where known information relating to a person's falls history had been identified as part of the pre-admission process a subsequent risk assessment and care plan was completed and there was evidence to show that appropriate healthcare services were sought for advice and involvement.

We asked the registered manager to review the staffing rosters between 1 April 2016 to 31 May 2016 and to clarify if there had been any staffing shortfalls on the residential and dementia units. The figures provided by

the registered manager confirmed that there had been a total of two shifts on the residential unit where they were one member of staff short. On the dementia unit there were a total of eight shifts where they were one member of staff short. The registered manager confirmed that there had been sufficient staff on duty at the time of the above incident and a further two incidents whereby people had sustained a bone fracture . At the time of this inspection staffing levels as told to us were being maintained.

Prior to our inspection we received information of concern from an external agency. The external agency advised that unexplained bruising had been found for one person. Staff confirmed that there were some people who could become anxious or distressed. Care plans for these people considered the reasons for people becoming anxious and the steps staff should take to reassure them. Guidance and directions on the best ways to support the person were in place so that staff had all of the information required to support the person appropriately and to reduce their anxiety. Staff were able to demonstrate a good understanding and knowledge of the support to be provided for individual people. We found no evidence to indicate that there had been an incident whereby the person with unexplained bruising had been injured as a result of others anxious or distressed behaviours. However, the record of the behaviours observed and the events that preceded and followed the behaviour required improvement so as to provide an adequate descriptive account of events which included staffs interventions and outcomes.

Requires Improvement

Is the service effective?

Our findings

Prior to our inspection a statutory notification was sent to the Care Quality Commission advising that a person who used the service had sustained a bone fracture whilst using an item of equipment to transfer from one place to another. The registered manager stated and records confirmed that 11 members of staff had attained a 'train the trainer' qualification relating to practical manual handling training and this enabled them to provide 'hands on' instruction for staff as and when required. However, the manual handling records of all care staff employed at the service were viewed and these showed that a total of 12 members of staff had not got evidence of up-to-date manual handling training. This related to five members of staff's training having last been undertaken in 2013 and 2014 respectively and seven members of staff whereby there was no evidence available to show that they had received manual handling training. We discussed this with the registered manager and they were unable to provide a rationale as to why staff had not received appropriate manual handling training. Although this showed that staff providing care to service users did not have the qualifications to carry out the above tasks safely, records showed that both members of staff who had provided support to the above person had got up-to-date manual handling training.

The providers 'Risk of Falls Management' policy recorded that staff should receive training on the prevention and management of falls as it was of 'paramount importance to ensure the health and safety needs of every resident are met.' The staff training matrix did not provide any evidence to show that falls related training had been provided to staff. We discussed this with the registered manager and they confirmed that this was accurate. Although staff had a basic understanding and knowledge of falls management, training and learning in this area this had not been considered which could ultimately assist staff in supporting people to remain independent and safe in relation to falls management.

Requires Improvement

Is the service well-led?

Our findings

Improvements were required to show that the provider's own quality assurance systems effectively analysed and evaluated information so as to identify where quality or safety for people using the service was compromised and to drive improvement. Also to keep up-to-date to ensure the service was delivering best practice in line with current legislation. There were gaps in staff training, particularly in relation to manual handling and the prevention and management of falls. Had there been a more effective quality assurance process in place, this would have identified the issues we identified during our inspection.

Falls audits were reviewed each month for the period January 2016 to May 2016. The incidence of falls had risen significantly between April 2016 and May 2016 from eight to 19 falls. We discussed this with the registered manager. Although the registered manager had recorded the number of falls, the times of falls and actions taken, they had not further analysed the information to investigate why there had been such a marked increase in falls for this period so as to identify any trends and future learning. Additionally the registered manager had failed to ensure that where a person had sustained an injury following a fall, particularly a head injury or suspected head injury, a close observation record was maintained so as to ensure the person's on-going health, safety and wellbeing. This related to the accident and incident records showing in some instances that people had sustained a head injury, for example, bruising and cuts to their head following a fall. We discussed this with the registered manager and they confirmed that the lack of close observation records for individual people was an oversight on their part. An assurance was provided that this would be completed for the future.

The registered manager confirmed that the management team had not kept employees up-to-date and informed of on-going research findings and outcomes and legislative guidance. For example, The National Institute for Health and Care Excellence [NICE] and The Social Care Institute for Excellence [SCIE] in relation to falls management and the prevention of falls.