Sunrise Operations Bassett Limited

Sunrise Operations Bassett Limited - Sunrise of Bassett

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**

Summary of findings

Overall summary

This inspection took place on 17 May 2016 and was unannounced. The home provides accommodation and personal care for up to 104 older people, including some people living with dementia and some with nursing care needs. The home had an assisted living area and a separate reminiscence area for people living with dementia. There were 61 people living at the home when we visited.

The home did not have a registered manager; however, the provider had appointed a new general manager for the service who had submitted an application to become the home's registered manager. 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.

At our last inspection, in May 2015, we told the provider to take action to make improvements in relation to keeping people safe and ensuring people received the nursing and medical care they required. We took enforcement action and required the provider to make improvements by 21 February 2016. The provider had identified a need to make changes to the home's senior management team; however the new team had not been in place long enough to ensure all the fundamental standards of quality and safety we assessed were being met.

At this inspection we found improvements had been made but further work was required to ensure people received effective care to meet their nursing and medical needs. Staff had not acted when routine observations indicated a change in a person's condition. They were not following the provider's policy or national guidance for monitoring people following head injuries and were not always managing wounds appropriately. New systems had been put in place to ensure action was taken following blood and other medical tests and to improve the quality of care plans and risk assessments for specific health care needs.

The provider's policy for the safe management of medicines helped ensure people were safe although staff had not always followed these consistently.

The provider and staff were aware of their responsibilities to safeguard people. Systems were in place to monitor incidents and where possible action was taken to reduce the risk of recurrence.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

The service was safe.

The provider and staff were aware of their responsibilities to safeguard people. Systems were in place to monitor incidents and where possible action was taken to reduce the risk of recurrence.

The provider's policy for the safe management of medicines helped ensure people were safe although staff had not always followed these consistently.

We could not change the rating for this key question from 'requires improvement' because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service effective?

Inspected but not rated

The service was not always effective.

The provider had identified that improvements in the way nursing and healthcare needs were met were required. However, changes were not yet in place or embedded into practice to ensure people always received effective care.

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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 consider if action had been taken to meet warning notices issued in December 2015. This inspection was not planned to provide a quality rating for the service.

This inspection took place on 17 May 2016 and was unannounced. The inspection was undertaken by two inspectors, a pharmacist inspector and a specialist advisor in the care of older people and those living with dementia.

Before the inspection we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. The registered manager completed 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.

We spoke with eight people living at the home. We observed care and staff interactions with people in communal areas. We spoke with the area manager and a manager from a nearby home owned by the provider who was supporting the service at the time of the inspection. We also spoke with 11 nursing or care staff on duty. We spoke with the local commissioning and safeguarding team. We looked at care plans and associated records for 16 people, medicines management records, records of accidents and incidents, safeguarding records, policies and procedures and quality assurance records.

Inspected but not rated

Is the service safe?

Our findings

At our previous inspection, in May 2015, we identified that people were not always safe and staff were not identifying and responding appropriately to safeguarding concerns. In December 2015 we issued a warning notice and told the provider they must make improvements to ensure people were safe. At this inspection we found improvements had been made.

Everyone we spoke with felt they were safe. One person said, "if you mean by safe do the staff keep me safe of course they do, I would not stay here otherwise". Another person told us "The staff keep me safe". We observed many interactions between staff and people in both areas of the home and saw that staff treated people with respect, kindness and patience.

One staff member told us "Staff were not aware [previously] of abuse between residents. That's changed. We safeguard a lot of incidents; staff are more vigilant and they have more knowledge. Residents seem happier and are doing more activities now". Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse, and how to contact external organisations for support if needed. They recognised factors that put particular people at increased risk of abuse and said they would have no hesitation in reporting incidents of abuse and were confident supervisors would act on their concerns. One staff member said "If I had any concerns I would make the [person safe] and then report it to [the care coordinator]. She would investigate it in confidence. If I needed to, I would go higher; I would whistle blow and would document it". The provider had appropriate policies in place to protect people from abuse which staff were aware of and put into practice.

We viewed referrals that staff had made to the local safeguarding authority. These were appropriate and showed there was a healthy working relationship between the home and the local safeguarding team. Investigations into allegations of abuse or suspected neglect were thorough. Actions to prevent recurrence had been considered and implemented promptly to help safeguard people from further abuse. For example, an error in the administration of one person's medicine had led to a review of the way medicines were managed and administered at the home. Additional checks of medicine records had been brought in; staff had received additional training and had had their competency to administer medicines reassessed. Where people had displayed aggressive behaviour towards others, records were made in a way that allowed staff to analyse the root causes and identify which responses supported and protected people most effectively. This information was then used to update people's care plans to minimise the risk of a similar situation arising again.

The effectiveness of medicines were appropriately monitored. We reviewed the care plans and records for three people prescribed medicines that required regular blood monitoring. These records contained test results, subsequent scheduled tests and the exact dose to administer. However, an additional care plan was not available for one other person prescribed a similar medicine. When we raised this with the staff, they took prompt action and prepared a care plan to support the person with this medicine. A further person lacked an additional care plan for two medicines prescribed under shared care arrangements between the hospital and the GP that required blood monitoring. One person was prescribed a "just in case medicine"

and their care plans contained supporting actions including how to summon expert advice. Information about allergies, 'how I like to take my medicines', 'when required' and 'variable dose' medicines was held within each person's medication administration record (MAR). However, this information was not always consistent, placing people at risk of not receiving their medicines correctly.

Some people were supported to maintain their independence by managing their own medicines. One person told us "I have my own medicines but they order them in good time each month". Three people were self-administering their medicines following the completion of a risk assessment. A further two people were self-administering some of their medicines; however, risk assessments to determine the level of support each person required had not been undertaken. Where people were self-administering their medicines they had been provided with suitable secure storage facilities. However, one person who was managing their own medicines was not using the secure medicines cupboard and told us they did not routinely lock their bedroom door. This meant other people could have accessed their medicines. Staff had not ensured the person followed safe medicines storage arrangements.

Medicines managed by staff were stored securely and those requiring refrigeration or stored in the treatment rooms were kept within recommended temperature ranges. We spoke with two registered nurses about their knowledge of medicines and found this was up to date and comprehensive. They told us they had received training in medicines management and administration and had competency assessments. We observed staff administering medicines to people in a patient manner and always informing the person what the medicines were. A person told us "They give me my medicines when I need them on time all the time". Staff did not hurry the medicines rounds and we found the MARs were up to date and complete. A care staff member explained how they applied prescribed topical creams to people as part of their personal care. We viewed topical cream administration records for three people. These were fully completed and stated the name of the product, when and where the topical creams had been applied.

Inspected but not rated

Is the service effective?

Our findings

At our previous inspection, in May 2015, we identified that people were not always receiving effective care to meet their nursing and medical needs. This included staff not acting when routine observations indicated a change in the person's condition, not following up blood and other medical tests, not monitoring people following head injuries and wound care. In December 2015 we issued a warning notice and told the provider they must make improvements to ensure people received effective care and treatment. At this inspection we found further work was required to ensure people received effective care to meet their medical needs.

People told us they felt their care needs were being met. One person told us "If I am ill they look after me and call the doctor". Another person said of the staff "They are friendly, efficient and kind". Staff said there had been a great deal to do after our previous inspection and 'things were bad then' but they were now greatly improved.

Records did not always include information about how bruising or skin injuries had occurred. For example, in one person's care plan it stated 'sustained a small skin tear to their right arm'. There was no measurement or other description or information as to how the injury occurred. We found other instances when there was no investigation into the cause of bruising or a skin injury. For example, one person had a significant bruise on their throat. A photograph had been taken as they also had a wound on their knee. There was no incident form or investigation into the bruise to their throat, the location of which could have meant other injuries in this delicate area may have occurred.

There were inconsistencies between the records made in the wound care book, those in care plans and incident records. The provider's wound assessment, care plan and dressing record document, when correctly used, provided a clear record of the wound assessment and management system. One record viewed showed staff identified when a wound was becoming infected and sought medical advice, resulting in the person being prescribed antibiotics. This person's record also showed the person was not in any pain and that external wound management advice had been sought. However, this was not the case for all wound records viewed and some were unclear and incomplete. For example, they did not include measurements or photographs which showed the size of the wounds or improvements and/or deterioration. In December 2015 the general manager completed the provider information return which stated all nurses had received tissue viability and wound care training. The inconsistencies and poor recording we identified occurred in records subsequent to this training. We could not be sure that people had all received appropriate wound care.

The provider's post falls policy listed minor wounds to skin including face and directed staff to 'observe the resident for 24 hours (inc vital signs)'. There was no clear guidance for staff as to what they should be observing, or how frequently observations should be made and where observations should be recorded. The policy guidance for major or serious injuries, including head injuries, directed staff to call 999 and follow ambulance instructions. For some people staff were undertaking post head injury observations but the frequency and duration of these varied. For example, one person who was seen by paramedics following a head injury which resulted in the person being unconscious for about 20 seconds. Staff recorded half hour

observations from 8.30 am until 1.30pm. There were no subsequent observations were made. The record of observations included a list at the bottom of the page to advise staff what to observe and signs that may indicate a deterioration in the person's condition. These included drowsiness. The records of the observations we saw repeatedly stated that the person said they were drowsy or tired. However, there was no reference to informing the nurse or the GP as detailed in the provider's policy. For another person there was a delay of several hours in commencing observations following a fall where a head injury had occurred. Once commenced, regular observations were undertaken overnight but were not continued the following day. In some instances records documented that paramedics had stated that no observations were required; for other people this was not recorded.

Staff did not always follow the specific guidance in people's care plans. For one person with epilepsy we saw their care plan stated staff should undertake 17 observations in the 24 hours following a seizure. However, staff could not find any records of these for the two seizures the person had experienced on 26 and 28 April 2016.

Nurses undertook monthly 'wellness' checks of all people. These included checking vital signs such as blood pressure, temperature and pulse. We found for one person, who had a known heart condition, no action had been taken when their pulse was recorded as lower than their normal reading. The acting general manager said "They should have responded to a change like this; at the very least made regular recordings to see and then contacted the GP if indicated. We have no idea from this what has happened during the past two weeks".

The failure to ensure people received all the health care they required is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For some people, who had specific needs, staff had written very detailed risk assessment and management plans. This included a person with epilepsy, another person with diabetes and a further person who had very frequent falls. These provided staff with information as to the care and support people required and what action staff should take should they have a concern the person's condition may have deteriorated. One person's risk assessment and care plan was updated following a fall and directed staff to remind the person to use their walking stick as they tended to put this down and forget to use it. We saw staff monitoring the person and reminding them to use their walking stick. We also heard staff encouraging the person to go for a walk, as detailed in their care plan, to help their mobility.

There was a system to monitor and analyse falls in each unit. This was comprehensive and looked at all relevant factors including the person who had fallen, place of fall and time of day. Action had been taken when this identified that there had been a high number of falls at staff handover time. Staff were required to update records throughout the day rather than at the end of their shift making them more available to support people at key times. This had resulted in a reduction in the number of falls. In the reminiscence unit the analysis had identified that most falls occurred between 14.00 and 21.00 hrs in communal areas. We were told a request for additional staff between these hours was being considered by the director of operations. Where people had fallen and may have suffered an injury to their head staff were following the provider's policy of consulting external medical practioners such as 111 or, following more serious falls, paramedics.

Nursing staff showed us the new system in place to help ensure any necessary action was taken following medical and blood tests. The system included staff recording when a blood or other medical test was taken and what action had occurred as a consequence, including when no further action was required. We found that with one exception there was a record of the outcome of all medical checks. In emergency situations

people were provided with emergency attention by nurses. For example, one person fell and staff identified a possible fracture to the person's hip, which was later confirmed in hospital. Records showed a nurse attended and staff kept the person safe and comfortable where they had fallen, and contacted paramedics.

The provider's senior management team had identified and taken action to make changes to the home's senior management team. A new senior nurse was due to commence their role and an experienced manager, who was a registered nurse from one of the provider's nearby homes was supporting the service at the time of the inspection. In the two weeks they had been at the home they told us they had identified areas requiring improvement and were working to implement changes. Some changes had already been put into place such as staff wearing red tabards when administering medicines to remind staff, people and visitors not to interrupt them. They had identified a need to review all care plans and ensure these had the level of detail required.

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
Treatment of disease, disorder or injury	The registered person has failed to ensure care and treatment has been provided in a safe way.

The enforcement action we took:

Warning notice