MACC Care Limited

Priestley Rose Nursing Home

Inspection report

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Date of inspection visit:
07 April 2016

Date of publication:
13 June 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 7 April 2016 and was unannounced. We carried out an unannounced comprehensive inspection of this service on 1 and 3 December 2015. After that inspection we received concerns from social services that a person that lived at the service may have sustained an avoidable injury. As a result we undertook a focused inspection to look into those concerns. 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 (Priestley Rose Nursing Home) on our website at www.cqc.org.uk.

Priestley Rose Nursing Home provides a service for up to 47 people. People living at this home may have a range of different nursing care needs. A registered nurse is available at all times. There were 41 people living there at the time of our inspection.

There was a registered manager in post at the time of our inspection. 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.

We previously inspected this service on 1 and 3 December 2015, at that inspection people told us they felt safe. During this inspection we found that although procedures were in place to assess and monitor the risks to people, they were not sufficiently effective to ensure people were safe at all times. Therefore appropriate actions were not always taken to reduce the risk of harm happening to people. Specific concerns were identified in regards to unguarded radiators and pipe works, which had the potential to put people at risk of harm.

You can see what action we told the provider to take 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?

Requires Improvement

The service was not consistently safe.

Environmental risks to people's safety were not always identified and managed effectively.

Priestley Rose Nursing 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 checked 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 7 April 2016 and was unannounced. The inspection was undertaken by one inspector. We undertook this focused inspection due to concerns reported to us by social services that a person that lived at the service may have sustained an avoidable injury. We inspected the service to check that people were safe, so we focused on inspecting the areas of concerns reported to us.

As part of our inspection we looked at the information we held about the service. This included, the last inspection report, notifications received from the provider accidents/incidents and safeguarding alerts which they are required to send us by law.

We spoke with the registered manager, two nurses, a care staff member, and the maintenance person. We looked at the care record of one person, did a tour of the premises and looked at safety records kept by the provider. We also looked at statements made by staff as well as the GP that visited the person that allegedly sustained the injury.

Requires Improvement

Is the service safe?

Our findings

We previously inspected this service on 1 and 3 December 2015, at that inspection people told us they felt safe. We received recent information which indicated that a person that lived at the home may have sustained blisters to their hands. Health care professionals indicated that the blisters were consistent with holding onto a hot radiator or piping. However, they said that without conclusive evidence it was difficult to know how the injury was sustained. During the inspection we spoke with staff about the needs of the person that had sustained the alleged injury. They all confirmed that it was unlikely that the person would have fallen out of bed and held onto the radiator or pipe. They said the person used bedrails whilst in bed, did not have any difficult to manage behaviours, and was not a restless person. All staff spoken with said that the person's chair was located on the opposite side of the room to the radiator. So the person did not sit near the radiator. Staff said the person needed a hoist to move them, from bed to chair, and it would have been difficult to use the hoist on the side of the room where the radiator was located.

Before we inspected the service we asked the provider to send us information relating to the position of the radiator that was located in the person's room. We saw that the radiator was unguarded; the provider told us they would fit a guard to the radiator. When we inspected the home, we saw that a radiator guard had now been fitted. However, the piping leading to the radiator remained exposed. The registered manager said she had already asked the maintenance person to cover the pipes and that this would be done before anyone else moved into the room.

We looked at the risk assessment completed for the room of the person that sustained the alleged injury and sampled the risk assessments for other people's rooms. We saw that they had not identified the unguarded radiators and pipe works as a potential risk to people.

We looked at a recent environmental risk audit completed by the registered manager and it stated covering to all exposed pipes and radiators, however this did not include a specific timescale for completion.

We saw that there were nine other bedrooms as well as two lounges that had unguarded radiators and hot pipe works that were uncovered. The registered manager told us she had requested that these be covered also. The maintenance person told us that the timescale for installing guards for the radiators and pipes was before next winter. We advised the registered manager that the timescale did not ensure people were safe. The maintenance person then said this would be completed by the end of May 2016. This was in breach of Regulation 12 of the Regulated Activities Regulations 2014.

We saw that there were systems in place for monitoring water safety including water temperatures and legionella risks. Fire safety procedures were in place. This included an external company undertaking fire risk assessments. We saw that wheelchairs and bed rails were checked, this included checking mattresses and that bed rail bumpers were fitted appropriately.

After the inspection we spoke with the provider about the timescale for undertaking the work to make the radiators safe. They confirmed that all the radiators and pipe works would be fitted with guards by 15 April

2016. We have we had confirmation form the provider that this work has been completed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of people using the service were not always effectively assessed. Reasonable and practicable actions were not taken to mitigate risks. Regulation 12 (1) (2) (a) (b)