General Medicare Ltd

Burnham Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

We carried out a comprehensive inspection of Burnham Lodge Nursing Home on 17 and 21 August 2017.

Following this inspection we served two Warning Notices for breaches under two separate regulations of the Health and Social Care Act 2008. In addition to this, we also found three further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have set requirement actions relating to these breaches.

We undertook a focused inspection on 6 December 2017 to check the provider was meeting the legal requirements for one of the regulations they had breached that resulted in them being served a Warning Notice. This focused inspection was to ensure the provider had taken sufficient action that ensured people were protected against the risks associated with receiving safe care and treatment and medicines. This report only covers our findings in relation to these areas. At the last inspection 'Safe' was rated inadequate. This rating will not change because this was not a full comprehensive inspection. You can read the report from our last comprehensive inspection, by selecting the 'All reports' link for 'Burnham Lodge Nursing Home' on our website at www.cqc.org.uk

Burnham Lodge Nursing Home accommodates up to 23 people in one building. At the time of our inspection, 17 people were living at the home. The home specialises in caring for older people including those with physical disabilities, people living with dementia or those who require end of life care.

There was 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.

During this focused inspection on 6 December 2017, we found action had been taken to ensure people received care and treatment in a safe way, risks to people's safety were assessed and mitigated and sufficient action had been taken to ensure compliance with the safe and proper management of medicines had been achieved.

Where risks were identified to people's safety, we found measures were in place to reduce the identified risks. Staff were aware of the risks relating to people and they were recording incidents when they occurred.

Clear protocols and guidelines were in place giving staff instruction on when and how 'when required' medicines should be given.

Risks relating to legionella bacteria in the water systems and high water temperatures were being managed consistently and safely.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

We found action had been taken to improve the safety of people's care.

Risks to people were identified and measures were put in place to reduce the risks. Staff were aware of these.

Guidelines and protocols were in place for people's medicines.

Risks relating to legionella bacteria in the water system and water temperatures were being managed.

Burnham Lodge 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.

Following our inspection on 17 and 21 August 2017, we served two Warning Notices for breaches of two separate regulations under the Health and Social Care Act 2008. We undertook a focused inspection of Burnham Lodge Nursing Home on 6 December 2017.

During this inspection we checked that the improvements required by the provider after our comprehensive inspection had been made in relation to one of those regulations.

The inspection was unannounced and undertaken by one inspector. The inspection involved inspecting the service against one of the five questions we ask about services which was, 'Is the service safe.'

During our inspection we spoke with the registered manager and five staff members. We looked at four people's care plans, records relating to medicines and health and safety checks.

Inadequate

Is the service safe?

Our findings

At the last inspection of this service on 17 and 21 August 2017 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some aspects of the service were not safe, risks to people were not always monitored and mitigated, some aspects of medicines were not being managed safely, and risks relating to legionella bacteria in the water systems and high water temperatures were not being managed consistently.
During this inspection we found that improvements had been made to ensure the provider was compliant with this regulation.

The manager told us following our last inspection processes had been put in place to ensure staff were aware of risks relating to people. Staff confirmed they had attended a staff meeting to discuss the concerns we found at our last inspection and the action required to make improvements. One staff member told us, "A staff meeting was held following the inspection and we looked at where we needed to improve. The communication is effective, we have all pulled together as a team and it's working really well." Another commented, "A staff meeting was called after the inspection for everyone to attend, the risks were highlighted and we discussed how we could improve and rectify the areas identified. It seems to be working well, things have been put in place and staff are embracing the change, things are flowing better and things are more organised."

Where people required bed rails on their bed to prevent them from falling out, we saw risk assessments were in place identifying the measures in place to prevent them becoming trapped in the rails. Where bedrails were deemed unsafe for people to use because they may attempt to climb over them, for example, this was clearly documented and the staff we spoke with were fully aware that they should not be using them. Bed rails were checked monthly by the registered manager to ensure they remained in good condition. We saw new bedrail covers had been purchased and put on the rails which ensured the risk of entrapment was reduced. This meant risks relating to people becoming trapped in the bedrails were being assessed and mitigated.

We found where one person was inclined to holding and scratching their own arms resulting in bruising, this was clearly documented in their care plan. The registered manager had put a body map in place for staff to record any new marks or bruising. Body maps are ways providers can record on paper, any marks and wounds found on a person's body to enable them to monitor these. The staff we spoke with told us they checked the person daily to note any new marks or bruises and they said if there were any they would report this to the nurse on duty.

At our last inspection we found where one person had a wound on their leg, this had not been dressed and a wound care plan was not in place. At this inspection we looked at one person's records where the person had a wound. We saw the wound was dressed and a care plan had been put in place to guide staff on the action they needed to take and address any potential risks. We saw the measures that were in place were being followed.

At our last inspection we found staff were not following people's guidelines in relation to observing them during their meals, staff were not clear about the content of the guidelines. The registered manager told us since our last inspection two people had been reassessed by a Speech and Language Therapist in relation to their eating and drinking, the staff we spoke with were aware of and following the guidelines.

People had individual guidelines in place that were written by health professionals where they were at risk of choking or aspirating whilst having food and drink. The guidelines included clear guidance on the required texture of the food and drink, the correct positioning of the person whilst they were eating and drinking and the staff observation required during the meal to ensure people remained safe.

We read the guidelines and spoke to staff about them. Staff were clear about the content of the guidelines and the level of observation they should be carrying out. They told us since our last inspection an allocated staff member was identified on each shift to ensure the observations were carried out. We saw this was recorded on the daily handover shift, they also confirmed they had all read the eating and drinking guidelines. We observed staff following these guidelines during our inspection.

During our last inspection we found some aspects of medicines management needed to be improved. At this inspection we found most of the improvements had been made. For example, where people required 'as and when' medicines we saw clear guidelines had been written instructing staff on when and how the medicines should be given for most of these medicines. We found one person had eye drops that were administered 'as required' and there were no guidelines in place to instruct staff when these should be administered. We discussed this with the nurse on duty who was clear about when they would be administered and told us the person would inform them of this. We discussed this with the registered manager who, following our inspection sent us a copy of the completed guideline that they had put in place.

Improvements had been made to prevent the risk of legionella bacteria in the water system and to prevent the risk of scalding. Weekly water temperatures were taken to ensure the water temperature remained within a safe range. Staff also took the temperature of the water each time a person was supported with a shower or bath. This meant risks to people's safety were identified and measures were in place to reduce the risk.