Runwood Homes Limited

Heron Court

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service in February 2016 at which time the service was rated as good in all domains.

Following on from that inspection we received information of concern in relation to the safe care and treatment of people, specifically regarding catheter care and management and treatment of urinary tract infections. As a result we undertook a focused inspection on 4 May 2017 to look into those concerns.

This report only covers our findings in relation to those topics at that time. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Heron Court on our website at www.cqc.org.uk.

Heron Court is a residential care home which is registered to provide accommodation and personal care for up to 35 people. 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.

At the time of inspection we found that people's care records did not always adequately reflect risks or provide sufficient detail for staff on how to manage those risks with regard to catheter care and risk of urinary tract infection (UTI's). However, risks were mitigated as staff knew the people they cared for very well. Staff demonstrated an excellent awareness of the risks to people and knew how to manage them to keep people safe .

Staff had received training in catheter care and were knowledgeable about urinary tract infections. They knew the signs to look for, could identify people at high risk and knew how to test for infections. Staff were aware of the importance of sharing this information with health professionals to ensure people received appropriate and timely treatment.

Whilst risks to people were alleviated by staff knowledge and experience, the potential for risk existed. Therefore we have recommended the service review how it ensures the safe and effective management of catheter care and UTI prevention.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were aware of risks to people and how to manage them.

We recommended the review of existing systems and processes for minimising risk.

Heron Court

Detailed findings

Background to this inspection

We previously carried out an unannounced comprehensive inspection in February 2016. At that time Heron Court was awarded a rating of 'Good' in all five key questions.

In response to information of concern we had received regarding the safe care and treatment of people we carried out an unannounced focused inspection of Heron Court under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We inspected the service against one of the five questions we ask about services: is the service safe?

The inspection was undertaken by one inspector. Before our inspection we reviewed all the information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events, which the provider is required to send us by law. We also reviewed information received from relatives of people who used the service.

During the inspection we spoke with the registered manager and five members of staff. We reviewed various documents including three people's care records and other documents central to people's health and well-being.

Good

Is the service safe?

Our findings

This focussed inspection was carried out in response to concerns raised regarding safe catheter care and managing and reducing risks to people of contracting urinary tract infections (UTI's).

We looked at the care records of two people who used the service who had indwelling catheters. An indwelling catheter is one which is inserted into the bladder and allowed to remain there. Both people had a catheter care plan listed in there care records but we were only able to look at one record as the other was missing from the file. We found that in both people's care records there were no specific risk assessments in place for their catheter care. Instead, information on risks and how to manage them was included in the catheter care plan, for instance, staff were instructed to ensure that the person's catheter bag was emptied regularly and that their urine was checked to ensure it was clear and free from blood. However, we found that the information recorded on catheter care risks was general rather than tailored to people's individual needs. For example, one person did not use a night catheter bag or stand, as they got up and walked about a lot at night and this would pose a trip hazard and put the person at increased risk of falls. This was important and relevant information to the person's care but it had not been recorded in their catheter care plan. Nonetheless, all of the staff we spoke with were aware of this information demonstrating they knew about risks to people and how to manage them.

We discussed our concerns about the lack of written guidance for staff with the registered manager who immediately addressed the issue and a more detailed risk assessment and management plan was added to the persons' care records.

We saw that both people had night care plans in place which also included some information for staff on catheter care. For example, instructions reminding staff to check and empty catheter bags and ensure that people had access to fluids throughout the night. However, we found that the written guidance for staff lacked detail and was poorly written. For example, in one person's night care plan it stated, "Staff to check catheter to see if it is in good work."

Whilst written care records did not always adequately reflect the risks to people or provide detailed guidance for staff on how to manage those risks, this was. Risks to people were mitigated due to the fact that staff knew the people they supported very well. All of the staff we spoke with were able to tell us which people had catheters or were at risk of getting a UTI and what needed to be done to reduce any risks to keep people safe.

The service had signed up to Prosper which was a programme developed by the local authority to promote safer provision of care in residential and nursing care homes. Part of the programme involved monitoring the incidents of UTI's within the home to identify people at risk so that measures could be put in place to reduce the risks. The service did this by keeping a monthly safety calendar which tracked all of the people who had developed UTI's.

We reviewed the safety calendar records for the past six months and saw that the names and dates recorded

matched the information held in people's care records. The names of people tracked on the safety calendar also corresponded with the names staff had given us of people who they felt were at particular risk. This demonstrated that the service was accurately identifying and monitoring people at risk and sharing information effectively with staff.

All of the staff we spoke to told us they had received training in catheter care from the deputy of the service who was a trained nurse and that additional training had also been provided by the district nurse. Staff also completed an E-learning module which emphasised the importance of hydration and how to recognise and treat UTI's. Staff demonstrated a very good level of knowledge of the signs and symptoms to look for that might tell them someone had a UTI. For example, they told us they would monitor the colour and odour of a person's urine and watch for traces of blood, changes in mood, confusion or sleepiness.

As part of the Prosper programme staff had all been trained in how to test for UTI's using a test strip to dip people's urine. Staff were aware of the reporting and referral process to ensure people received timely treatment such as antibiotics from the GP. Care records we reviewed confirmed that people at risk had been monitored, urine tests had been completed and if positive referrals were made to the GP or district nurse for treatment. We saw that one person who had been tracked as having frequent UTI's was now on long term antibiotics as a preventative measure.

For those people identified at risk of dehydration, which can cause UTI's, fluid charts were kept to measure how much they drank every day. The charts were checked daily by senior members of staff who signed to say they had reviewed the information. The registered manager told us that if people failed to meet their fluid targets for more than two days in a row, referrals would be made to the appropriate health professional for advice and treatment as appropriate.

People with indwelling catheters also had an additional fluid balance recording chart in place which was used to record the date catheter bags were changed and if any change was noted to alert staff if people were becoming unwell. The form also recorded fluid input and urine output. Monitoring urine output can be an effective means of identifying if people are at risk as low output can be a symptom of dehydration or ill health. However, we found that these forms did not always record everything that people had drank in a day so did not provide an accurate picture of people's fluid balance overall. Nonetheless, their fluid intake was consistently recorded on a standard fluid chart kept in their care records. This meant that staff did have access to all of the relevant information to assess risks to people but it was not as efficiently organised as it could be to ensure safe and effective oversight.

Measures were in place to ensure all people who lived at the service remained hydrated to reduce the risk of UTI's. A tea trolley went round in the mornings and afternoons to provide people with a choice of drinks. We saw that people had jugs of drink within reach in communal areas and also in their bedrooms. In addition, the service had also recently introduced a nutrition and hydration trolley which came round at 11am every day. This provided people with fortified food with a high hydration content such as ice-cream, smoothies, jelly and melon.

Any risks to people were mitigated by staff knowledge and experience of people who used the service. However, the potential for risk existed should new or agency staff be on duty who may not be as familiar or knowledgeable with people's individual needs. Therefore we recommend that the service review its current system of recording information on risk and make sure sufficient written guidance for staff is accessible to ensure the safe management of catheter care and UTI prevention.