Rushcliffe Care Limited

Partridge Care Centre

Inspection report

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Overall summary

We carried out an unannounced focused inspection of this service on 23 July 2015 in response to concerns raised. At that inspection we found that the provider was not meeting a number the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This focused inspection took place on the 19 August 2015 and was unannounced. We undertook this inspection to assess the level of risks to people who used the service following information of concern received from partner agencies. This report only covers our findings in relation to this area. You can read the report from our comprehensive inspection carried out 23 July 2015 by selecting the 'all reports' link for Partridge Care Centre on our website at www.cqc.org.uk.

Partridge Care Centre is a purpose built home set over three floors. It provides personal and nursing care for up to 117 older people, some of whom live with dementia. At the time of our inspection a total of 80 people used the service, two of whom were in hospital.

We found that some actions had been taken to mitigate the immediate risks to people's health, safety and well-being and that the provider was working with an external consultancy arranged by the local authority to identify priorities and make improvements. This included in areas of shortfall such as staffing deployment, responding to incidents and concerns and the administration of medicines. We found that some actions had been taken to start addressing these concerns and mitigate the immediate risks to people but further work was needed to ensure people's safety and well-being.

There was a manager in post who was not currently registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 did not change the ratings as a result of this inspection. To improve the rating for a key question requires consistent improvement over time. We will check this during our next comprehensive inspection.

At our inspection on 23 July 2015 we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we did not have sufficient evidence to demonstrate that these breaches had been met.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

This service was not always safe.

There was insufficient guidance available for staff to ensure that risks to people's health, safety and welfare were reduced or minimised.

Assessments to ensure that equipment was appropriate for people's needs had not been completed. Equipment was not always used safely and actions were not always taken to ensure that people were protected against the risk of infection.

People were not protected against the risks of them accessing unsafe items such as chemical cleaners.

Partridge Care Centre

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. We carried out the inspection to specifically look at the safety of the service due to the level of concern identified at our previous inspection on 23 July 2015 and subsequently by health and social care professionals.

This inspection was carried out on the 19 August 2015 and was unannounced. The inspection team consisted of three inspectors and a specialist professional advisor.

Before the inspection we reviewed information we held about the service and liaised with local authority commissioning teams, safeguarding teams and other partner agencies.

During the inspection we carried out observations in communal areas. We spoke with eight people who lived at the home, four relatives and 14 staff members. We also spoke with a visiting social care professional, the manager, a member of the provider's senior management team and an external consultant that had been secured by the local authority to support the manager in making improvements. We looked at care records relating to ten people and other documentation relating to the safety and welfare of people who used the service.

Is the service safe?

Our findings

At our inspection on 23 July 2015 we had found that the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safeguarding people from abuse, staffing, medicines and risk management which were having an impact on the safety and well-being of people who used the service.

At our inspection on 19 August 2015 we found that people's care plans included assessments for areas such as moving and handling, the risk of falls, use of wheelchairs, risk of poor nutrition, risks of choking, risk of developing pressure sores and risks associated with the use of bed rails. However, these assessments were in a tick box format with little individualised information to provide guidance for staff to maximise people's safety. For example, a risk assessment stated that a person was at high risk when being hoisted but did not indicate what the risk was, how it could be reduced or removed or what type of hoist should be used. This meant that risks to people's safety were not effectively assessed or managed.

The needs of people who were unable to mobilise independently had not always been assessed by suitable qualified people. We saw mobility care plans which detailed how staff should assist people to move. However, the assessments that the care plans were based upon had been carried out by nursing staff. These care plans included details of the equipment staff should use to assist people such as hoists to help people transfer for example, out of bed into a chair. The manager was not able to tell us which equipment had been identified as appropriate by occupational or physiotherapy staff or how the nursing staff had been assessed as competent to carry out these assessments.

At our inspection on 23 July 2015 we had found that equipment used in the home, such as wheelchairs, hoists and crash mattresses were not clean. At this inspection we found that the equipment used at the home was generally clean. However, people who required assistance to move by means of a mechanical hoist did not have individual slings and we found that these were a shared resource. This is not appropriate practice in terms of infection control or maintaining people's dignity.

A senior member of the management team told us that equipment necessary to support staff to provide safe care for people such as slide sheets were readily available withih the home. However, staff told us there were occasions where there was not enough equipment available to support them to provide people with safe care and support. For example, slide sheets are items of equipment that are used to safely support people to reposition in bed. Staff told us there was only one slide sheet available on one unit in the home and that there had been incidents where people's bed sheets had been used to re-position them. This is not safe practice as there are potential risks from friction. We were told by staff that this equipment shortage had been reported to management but not resolved.

Some people used stand aid hoists to enable them to be assisted in standing from a bed or a chair. We observed an occasion where staff did not use a stand aid sling correctly. The sling was not fitted tight enough and it rode up to the person's shoulders which meant they were at risk of falling through. During our inspection we found that people were at risk because equipment was not used safely.

At our inspection 23 July 2015 we identified concerns with the deployment of staff to meet people's needs. At this inspection people told us that there were sufficient staff available when they needed assistance. One person said "I occasionally have to wait but not too long.... [staff] never rush us and always spend as long as it takes." Staff told us that there were now usually enough staff to meet people's needs. However, when colleagues did not come into work at short notice due to sickness this put pressure on the remaining staff team as cover was not always available immediately. The manager explained that he had worked with staff to make sure they gave sufficient notice of any absence so that cover could be arranged.

The manager told us, and staff confirmed that they had worked with staff to identify the numbers needed on each unit to meet people's needs. However, staff explained to us that some people who used the service had complex behavioural needs which meant that their demeanour could change very quickly and they could become resistive to care. For example, a person that had been assessed as requiring 15 minutes support from staff with their personal care could take considerably longer if they became anxious and unsettled. This meant that there were not always sufficient members of staff available to meet and respond to people's changing needs.

Is the service safe?

During the course of the inspection we noted that people were responded to promptly when they required assistance and that staff were available in communal areas spending time talking with people. We did note however, that there were a number of people who were cared for in bed. Staff told us that they visited people in their rooms to ensure they were safe but said there were no arrangements in place to monitor this and ensure that each person was checked regularly.

We noted that some people did not have nurse call bells within reach which meant they could not attract the attention of staff if they required assistance. In one room we saw that the call bell cord was long enough to reach to the person's bed but not to the armchair where they were seated during the day. In another room we saw that the call bell was within reach but in positioned in such a way as to cause an obstruction or hazard the way if the person attempted to stand. This created a potential risk of injury if the person tripped and fell over the cord.

At our inspection on 23 July 2015 we found that sluice doors were unlocked which meant that people could access unsafe items such as chemical cleaners. At our inspection on 19 August 2015 we found on four occasions throughout the day on different units the sluice doors were unlocked. We brought this to the attention of the manager who explained that the importance of keeping the sluice doors locked had been reinforced with staff and assured us that this was an area that senior staff would continue to monitor.

At our inspection on 23 July 2015 we identified concerns in relation to the administration of medicines. During this inspection we looked at the storage and administration of medicines on three of the five units in the home. We reviewed a sample of records and checked the totals of a selection of boxed medicines and found that the medicines were correctly accounted for. The manager explained they had met with all of the staff responsible for administering medicines, explained their responsibilities and assessed their competence to administer them safely. Staff confirmed this and told us that, where needed, they had been given additional support.

One team leader explained that they carried out daily checks to make sure that medicines had been administered as prescribed. A nurse reported that they had attended two training sessions in the past six weeks, one through the provider and an advanced training session delivered by an external pharmacy. Staff told us that because staffing levels had improved it meant that they were able to administer people's medicines with fewer interruptions and therefore reduce the risks of errors.

At our inspection on 23 July 2015 we found that not all staff were aware of their responsibilities to safeguard people from abuse and avoidable harm. We also found that the safeguarding concerns within the home had been identified by external professionals rather than either the staff or management within the service. At this inspection we spoke with staff about protecting people who lived at the service from abuse. Staff were confidently able to describe what constituted abuse and said that they would escalate any concerns they had. At the time of this inspection there were some safeguarding matters that remained under investigation by the local authority safeguarding team.

The manager explained that since our last inspection they had spent time on the individual units talking with staff about their responsibilities and guiding their practice. For example, they discussed the action to take if protective bumpers were missing from someone's bedrails. Staff were able to describe the actions they would take in the event of an accident or incident. For example, they said they would use the call bell to summon a care team leader or nurse to check a person that had fallen and take the relevant actions needed to keep them safe. They said they would then complete an incident report form which would be passed to the manager for them to monitor for recurring themes or trends.