St Philips Care Limited

Pine Trees Care Centre

Inspection report

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Ratings

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

Summary of findings

Overall summary

Pine Trees Care Centre is a care home which provides accommodation for up to 35 older people who require support with personal care. Some of the people who lived at Pine Trees Care Centre needed care and support due to dementia and some people had sensory and /or physical disabilities.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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 carried out a comprehensive inspection of Pine Trees Care Centre between 1 February 2017 and 6 February 2017. At that inspection we identified six breaches of the legal requirements. The breaches related to how medicines were managed; staffing levels; staff recruitment checks; CQC not being notified about matters the provider was legally required to tell us about; the complaints procedure, and quality assurance processes. Two warning notices were issued regarding medicines management and staffing levels. Statutory requirements were issued about the other four breaches in the regulations. The provider sent the Care Quality Commission an action plan about the four requirements, and about actions taken regarding medicines management. We have also requested a report about actions taken regarding our concerns about staffing levels but this has not as yet been received.

We carried out this focused inspection to check if the registered persons had taken suitable action about the warning notice issued about the management of medicines. The other breaches in regulations will be looked at again at future inspections.

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 Pine Trees Care Centre on our website at www.cqc.org.uk

During this inspection we checked the service's medicines system. The organisation of the medicines system had improved but we still found some errors. For example there were some medicines which had been signed for but had not been administered. There were some medicines which had been administered but not signed for. Eye and ear drops and ointments were not labelled when they were opened for use. These should be disposed of after four weeks of use. Some of these medicines were being used, but had been dispensed more than four weeks before the inspection. Records about the administration of creams had improved, but still lacked sufficient detail to demonstrate they were being administered according to prescription instructions.

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

The service was not safe. Although some improvements had been made to ensure medicines were suitably administered, managed and stored securely, we still found some errors in the operation of the system.

Pine Trees 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. 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, 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 9 May 2017. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. The inspection team consisted of one inspector.

The inspection was to review what action had been taken to meet the breaches in regulation identified during the comprehensive inspection completed in February 2017 in relation to the management of medicines.

Before the inspection we requested a report about what action was taken by the registered persons about the breach in regulation. This was provided and seemed satisfactory. We reviewed previous inspection reports and other information we held about the service. We also looked at notifications we had received from the service. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection people we spoke with one person who used the service. We spoke with the registered manager of the service, and one visiting professional. We inspected the medicines system. We inspected four records relating to the care of individuals, and the records relating to the operation of the medicines system.

Inadequate

Is the service safe?

Our findings

At our inspection in February 2017 we found the medicines system was not operating satisfactorily. For example records about the administration of medicines were not accurate, and we found a significant number of errors with the operation of the system, for example medicines being given but not signed for, and medicines being signed for but not given. We were also concerned about whether prescribed creams and ointments were being applied as necessary and whether records of prescribed creams and ointments were being suitably kept. This was a repeated breach in the regulations, as we found similar problems, and issued a statutory requirement, when we inspected the service in April 2016. As a consequence we issued a warning notice on 13 March 2017 which informed the registered persons that they must take suitable action by 1 May 2017 to ensure the medicines management system was operating effectively.

As a consequence of the warning notice, we requested the registered persons' inform us in writing of what actions they had taken. We received a detailed report which stated for example that regular audits were occurring.

At this inspection we found there had been some improvement in the operation of the medicines system. For example there were significantly less errors in staff signing for medicines, and the system was much tidier. For example we found no medicines left in pots which had not been administered. We spoke with one person who said staff always administered their creams. We also spoke with a district nurse who said the district nurse service had less concerns about staff not administering creams, and not taking suitable actions to minimise the risk of people having sore skin or pressure damage.

However we did find some errors in the operation of the system. In regard to staff signing for medicines they administered, we found for example two instances, for two people, on the same date, when a member of staff appeared to have administered medicines but had not signed for them. We also found, for example, one instance, where medicine was not given, and no reason was recorded on the medicine record sheet as to why this was.

We had concerns about the management of eye and ear ointments, and eye and ear drops. For example staff had not recorded the dates when these medicines began to be used. This was important as the packaging clearly stated that this medicine had to be disposed of within four weeks of the medicine being first used. We found, for example, three instances where the medicine had been dispensed from the pharmacy at least four weeks before the date of the inspection, and the medicine was still being used. There was no record to assure us that these medicines had only started to be used within the last four weeks. Where these medicines were administered after four weeks of opening they could be ineffective.

We found two errors regarding the management of medicines which required stricter controls of storage and recording. For example the totals for two different medicines being stored in this manner were incorrect.

Medicines within the service were mostly stored in blister packs supplied by the pharmacist. The blister packs were attached together, on a rack, according to the time medicines were administered. However we

found, for example, at least four blister packs which were not attached to the relevant rack. This meant there was a heightened risk staff could overlook administering these medicines. We discussed this with the registered manager, and she said she would arrange for the blister packs to be arranged appropriately.

The management of medicines which had not been used and needed to be returned to the pharmacist (for example people had refused the medicine, the person had died, or the prescription had changed) was not being carried out appropriately. A box of medicines which required return to the pharmacist was stored in a locked cupboard, and there was a returns book to record medicines which needed to be sent back to the pharmacist. However we found a significant number of instances where medicines were stored in the box for return, but were not entered in the returns book. We discussed this matter with the registered manager, and she could not provide any reason why staff had not made a written record. This was a concern because the medicines could be stolen, or not accounted for should an audit be completed.

The registered persons had introduced an electronic recording system. This included verifying when staff administered creams and lotions to people who used the service. From assessing the records kept it seemed that creams and lotions were being administered on a regular basis. However there was no breakdown of what creams and lotions were administered to an individual. The system only recorded that creams and lotions were administered, and not for example if two or more specific items were administered. The system did not therefore provide us with assurance, or an accurate medicine administration record, of all prescribed items being administered.

The on-going breach in this regulation was discussed at a CQC management review. It was agreed there had been some improvement in the operation of the medicines system since the last inspection, but it was still judged the regulations were being breached. It was decided to reissue a statutory requirement about the operation of the medicines system, and to re-inspect the medicines system at a later date.

This was an on-going breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The medicines system was not being effectively managed