Cotdean Nursing Homes Limited

Oaklands Care Home

Inspection report

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Ratings

Is the service safe?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection of this service on 30 October 2014. At which a breach of legal requirements was found. This was because the provider had failed to handle and administer prescribed medicines in such a way as to maintain and promote peoples good health.

After this comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook a focused inspection on the 18 May 2015 to check that they had followed their plan and to confirm that they now met legal requirements. We found that the provider remained in breach of Regulation 13 in relation to medicines management and in response to this we issued a warning notice on 13 July 2015.

We undertook this focused unannounced inspection on 15 September 2015 to check that the provider had made and sustained the improvements they had told us they would make following our last inspection on 18 May 2015, when we issued enforcement action. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oaklands Care Home on our website at www.cqc.org.uk

Oaklands Care Home is registered to accommodate and deliver nursing and personal care to a maximum of 40 older people. People using the service had a range of needs which included physical and mental health needs and old age. At the time of our inspection 31 people were living there.

The service had a registered manager at the time of our inspections. A registered manager is a person who has registered with the Care Quality Commission (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.

At this inspection of 15 September 2015, we found that the provider had not taken sufficient action to meet the

Summary of findings

legal requirements of the regulation. We found that medicines were not consistently administered in a safe manner and/or in line with the prescribing practitioner's and/or manufacturer's instructions.

Due to the provider's continued failure to fully meet the requirements of the law, we are currently considering what further action we will take.

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?

Inadequate 

We found that sufficient action had not been taken to improve the safety of medicines management.

People were not consistently provided with their medicines as prescribed. We found that staff lacked knowledge about how prescribed antibiotics should be administered in order to ensure their efficacy.

We found continued issues in relation to the safety of administration of medicines for people via a tube into their stomach.

The provider had failed to fully meet the requirements of the law and the warning notice issued by us in July 2015 in relation to the safety of their administration and management of medicines; we are currently considering what further action we will take.

We could not improve the rating for safe from Inadequate because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive Inspection.

Oaklands Care 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 was planned to check whether the provider was 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.

We undertook this focused inspection of Oaklands Care Home on 15 September 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our inspection on 18 May 2015 had been made and sustained. We inspected the service against one of the five questions we ask about services: is the service safe. This is because the service was not meeting some of the legal requirements in relation to that question.

The inspection was undertaken by a pharmacy inspector. We spoke with the registered manager, deputy manager, three people using the service and one relative. We reviewed the arrangements the service had in place for the recording, storage and safe administration of medicines.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection of Oaklands Care Home on 30 October 2014 we found that the provider had failed to handle and administer prescribed medicines in such a way as to maintain and promote peoples good health. Medicines management arrangements at the service were not robust. We observed that people did not always receive their medication in a timely manner and records in relation to the administration of medicines had omissions that were not accounted for.

This was a breach of the Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our focused inspection 15 May 2015, we found the provider had not taken appropriate action to improve and sustain how medicines were managed in order to meet the requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Prior to 1 April 2015 known as Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). We issued a warning notice for Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010) in response to this continued breach of the law.

At this our most recent focused inspection of 15 September 2015, we found that the provider had failed to make and sustain the necessary improvements in relation to the requirements of the warning notice for Regulation 13 described above.

We looked in detail at nine medicine administration records (MAR) and found that people were on the whole receiving their medicines as prescribed at the frequency and dose they had been prescribed by their doctor. However, four people who had been prescribed a blood thinning medicine were not consistently having their medicines administered to them as prescribed. For example, over a three week period we found that one person had received the wrong dose on two occasions, one person had not received their dose at all on one occasion and the audit of another person's medicines showed that there was one tablet more that there should have been. This meant that the provider had failed to monitor the safe administration of blood thinning medicines effectively. We reviewed the MAR for two people who were prescribed an antibiotic which needed to be administered on an empty stomach. Staff we spoke with were not aware of this and as a consequence these two people were receiving them with or just after their meals, which meant the antibiotic would not work properly.

We found the provider had developed a protocol to direct staff on how to specifically prepare and administer medicines through a tube directly into their stomach. We found that the protocol developed would not ensure the medicines were given safely as the provider was not flushing the tube between the administrations of each medicine. We were told by the provider that the person was restricted on the amount of water they were able to have and this was the reason the protocol had been developed in this way. The provider agreed to consult the community dietician about the amount of water that could be used to ensure the medicines were administered safely.

Medicines were found to be stored securely. Maintaining records and monitoring fridge temperatures is necessary to ensure the medicines being stored are kept at the correct temperature in order to maintain their effectiveness. However we found temperatures of the refrigerator were not being monitored on a daily basis. Where the temperatures of the refrigerator had been measured and recorded they demonstrated that the temperature of the refrigerator was being maintained above the expected maximum temperature of eight degrees celsius. On this occasion the medicines being stored in the refrigerator could be stored above eight degrees celsius for a short period of time. The contents of the refrigerator were still within this time frame and as a consequence there was no negative impact of the people using the service.

This is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Due to the providers continued failure to fully meet the requirements of the law, we are currently considering what further action we will take.

We reviewed the records for people who were having analgesic skin patches applied to their bodies. We found the provider was making a good record of where the patches were being applied. We looked at three of these records and found that the patches were being applied in accordance with the manufacturer's guidelines. The provider therefore was able to demonstrate that these

Inadequate

Is the service safe?

patches were being applied safely and people's pain would be well controlled. We spoke with a person using their service and their relative and they confirmed that their pain was being well controlled.

We found that people who were administering some of their own medicines were being supported to do this. We spoke with two people who had expressed a wish to administer their own medicines and they told us that they were well supported to administer their medicines and to store them safely. The risks associated related to self-administration of medicines had been assessed by the provider. We found the provider was regularly monitoring these people to ensure that they were well and had the continued level of ability to administer their own medicines appropriately.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to protect people using the service against the risks associated with the unsafe use and management of medicines.