Care UK Community Partnerships Ltd

Smyth Lodge

Inspection report

2 Frognal Avenue
Sidcup
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Tel: 02080519190

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07 July 2020

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31 July 2020

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Smyth Lodge is a care home and respite service set over three floors which provides residential care and support, nursing care and dementia care for up to 80 older people. At the time of our inspection 29 people were living at the service.

People's experience of using this service and what we found
There were safe systems and processes in place to ensure medicines were managed safely. Staff received the appropriate training and support to be able to administer medicines in a safe way and any errors were investigated thoroughly the management team at the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 14 May 2020) and there were multiple breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulation 12 in relation to medicines.

Why we inspected
We undertook this targeted inspection to check on a specific concern we had about medicines management. We found no evidence during this inspection that people were at risk of harm from this concern. Please see the safe section of this full report. However, the overall rating for the service has not changed following this targeted inspection and remains inadequate.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of

inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Smyth Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act.

This was a targeted inspection to check on a specific concern we had about medicines management.

Inspection team
The inspection was carried out by a medicines inspector.

Service and service type
Smyth Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not currently have a manager registered with the Care Quality Commission. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced on the morning of the inspection. We wanted to ensure the service could facilitate the inspection safely.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We reviewed the medicines administration records and care records for 10 people. We spoke with five members of staff, including two relief managers, the lead quality development manager, one nurse manager and one deputy manager. On the day of inspection, there were also three team leaders, trained in the safe administration of medicines and four care workers on duty at the home.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. We have not changed the rating of this key question, as we have only looked at the part we had specific concerns about.

The purpose of this inspection was to check a specific concerns we had about medicines management. We will assess all of the key question at the next comprehensive inspection of the service.

Using medicines safely
At our last inspection the provider had failed to ensure the safe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- The service had employed new staff who were inducted into the service appropriately and spent time shadowing others.
- Staff involved in the management of medicines were trained and had been assessed as competent to administer medicines safely. Staff had completed training in the management of diabetes, including how the medicines to manage this condition should be administered.
- A dementia champion trained staff to use activities to engage people and to de-escalate situations when people became agitated. This meant that medicines prescribed on a when required basis to sedate people when agitated, were only used if necessary as a last resort.
- Records showed that people's medicines were available to them when needed and were administered at the appropriate times. The service produced reports when medicines were not given on time. When a person had refused their medicines, staff returned to the person at the end of the medicines round to try again. Staff referred people to the GP or mental health team when they continued to refuse their medicines.

- People's allergy status was recorded and visible to those administering medicines. This helped reduce risks associated with medicines administration.
- Guidance and care plans detailed how people should be supported and monitored when taking their medicines. Staff followed protocols for medicines prescribed on a when required (PRN) basis so that they knew in what circumstances these should be given. These were reviewed and updated regularly.
- People's medicines were reviewed by the GP and the service had support from community nursing teams for people who were receiving end of life care.
- Medicines were stored safely and securely. Controlled drugs were managed in line with legal requirements and the provider's policy.
- Managers conducted audits to check safe systems and processes were followed in regard to medicines management; any discrepancies were discussed with staff to reduce the risk of repeat occurrence.

● Managers had spent time to ensure staff felt confident to use electronic medicines record systems effectively.
● Staff said that there was a culture of openness and that they felt supported to report errors and concerns.