Florence House Limited

Florence House

Inspection report

The Old Vicarage
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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement

Overall summary

We inspected Florence House on 17 August 2015. The home was providing a service to 26 people on the day of our visit.

We carried out an unannounced comprehensive inspection of this service on 22 and 29 May 2015. At the May inspection we found the provider was not meeting the legal requirements of five of the fundamental standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and one of the standards of the CQC (Registration) Regulations 2009. After the comprehensive inspection, we took enforcement action and issued two warning notices to require the provider to meet the legal requirements of two of the fundamental standards (Regulation 11 and Regulation 12).

This inspection in August 2015 was to check they had met the legal requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which relates to people's safe care and treatment and Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which relates to consent to care and treatment. This report covers our findings in relation to these requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Florence House on our website at www.cqc.org.uk

Since May 2015 the provider had improved the system for the management of medicines. Medicine records were clear and detailed all medicines people were prescribed.

Summary of findings

However there were still improvements needed as medicines records were not always completed and balances of medicines did not always show people had received their medicines as prescribed.

Since May some staff had received training in the Mental Capacity Act 2005 (MCA) and had a clear understanding of how to support people who may lack capacity. The Mental Capacity Act 2005 protects people who can't make some or all decisions for themselves. However, care plans did not always contain clear information relating to people's capacity and did not follow the principles of the MCA.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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

The service was not always safe.

We found that action had been taken to improve safety of medicines, however medicines records were not always completed and we could not be sure people received their medicines as prescribed.

We could not improve the rating for this key question from inadequate to requires improvement as we did not inspect all key lines of enquiry at this inspection.

We will check this during our next inspection.

Is the service effective?

Requires improvement

The service was not always effective.

We found that staff had good knowledge of the Mental Capacity Act (2005) and their role in supporting people who lacked capacity. However care plans did not always contain clear information relating to people's capacity.

We could not improve the rating for this key question from requires improvement because to do so requires consistent good practice over time.

We will check this during our next inspection.

Florence House

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 undertook an unannounced focused inspection of Florence House on 17 August 2015. The inspection team consisted of two adult social care inspectors and two pharmacy inspectors. This inspection was done to check that improvements to meet legal requirements planned by the provider after our inspection in May 2015 had been made. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service effective. This is because the service was not meeting some legal requirements and regulations associated with the Health and Social Care Act 2008.

During our inspection we looked at six people's care records and medicines records for all people using the service. We spoke with the provider, the registered manager, the deputy manager and five members of the care team.

Inadequate

Is the service safe?

Our findings

During our last inspection in May 2015 we found the provider did not have a proper and safe system in place in relation to medicines. There was no effective system to monitor the medicines being received into the home. Medicine administration records (MAR) were not always completed accurately. There was no effective system for auditing medicines to ensure errors were identified. Nurses were not administering medicines in line with the providers medicines policy.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action advising the provider they must make improvements to meet the legal requirements by 30 June 2015.

At the August 2015 inspection we found some improvements had been made. However, there were still improvements needed.

People were at risk of not always receiving their medicines as prescribed. We looked at the medicines administration record (MAR) for all people living in the home.

MAR were not always completed accurately. Where there were gaps on the MAR the balance of medicines recorded showed the medicine had not been given. There was no explanation recorded as to why the medicine had not been given.

Stock balances of people's medicines were recorded on MAR after each administration. However, on five people's MAR we found the balance recorded indicated people had not always been given the correct dose of their prescribed medicines.

One person was prescribed inhalers. The inhalers had been removed from the outer packaging and contained no details of the person they were prescribed for or dosage instructions. This meant staff administering the inhalers did not know if they were administering them as prescribed.

Nurses did not always administer and record medicines in line with the organisations policy. Medicines were signed as administered before the person had been observed taking the medicines. We spoke to the registered manager who told us this had been identified through observing practice and discussed at staff meetings, however we observed this method of recording and administration was used during our inspection.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had introduced a printed MAR that clearly identified people's medicines and instructions for administration. MAR were checked and signed by the GP each month to ensure medicines were recorded as prescribed.

A policy for the use of domestic remedies, to treat minor ailments, had been agreed with the doctor. Appropriate records were in place for the use of these medicines.

Medicines were stored safely. People's medicines were stored in individual trays. Trays were labelled with the person's name and medicines in each tray were for the correct person.

The provider had reviewed and updated the medicines policy. All staff responsible for the administration of medicines had received a copy of the policy. The policy had been discussed at staff meetings. We spoke to one nurse who confirmed they had received a copy of the policy.

Staff who administered medicines were completing a written medicines course. The registered manager told us that staff competencies would be assessed when the course had been completed.

Requires improvement

Is the service effective?

Our findings

During our inspection in May 2015 we found the provider was not adhering to the principles of the Mental Capacity Act 2015 (MCA) and associated codes of practice. The Mental Capacity Act 2005 protects people who can't make some or all decisions for themselves. Care plans contained conflicting information regarding people's capacity to make decisions. Where people were assessed as lacking capacity there was no record of decisions being made in the person's best interests. Staff had little understanding of the MCA. They were unaware of the principles of the MCA and associated codes of practice.

These were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 17 August 2015 we found improvements had been made, however there were still improvements needed.

People who lacked capacity to consent to decisions about their care were at risk of receiving care that had not been agreed using a best interest process. For example, one person's care plan stated they were using bed rails. There was no record of a best interest decision being made. We spoke to the registered manager who was unclear about the best interest decision making process when it was not associated with Deprivation of Liberty Safeguards (DoLS). DoLS aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom.

Care plans contained conflicting information in relation to people's mental capacity to make decisions. For example one person had signed a consent to care and treatment form. However there was a registered lasting power of attorney for health and welfare that predated the consent form.

Consent forms were signed by relatives who had no legal powers to make decisions on people's behalf. There was no evidence of a best interest process being followed. This did not follow the principles of the MCA.

These were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff we spoke with had an understanding of the Mental Capacity Act 2005 (MCA) and were able to explain how best interest decisions were made for people who lacked capacity to make decisions about their care. One care worker said, "We must always work in people's best interest. We would never force them [people] to do something they didn't want to". Care staff explained how they would encourage and support people who were unable to consent to care.

Care staff we spoke with had completed training in MCA, which included a knowledge assessment. The registered manager, deputy manager and nurses were all enrolled on the local authority MCA training which was due to start in September 2015.

Some care plans contained correctly completed decision specific capacity assessments to identify whether people had capacity to make decisions relating to their care.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way as there was not proper and safe management of medicines. Regulation 12 (1) (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider was not following the principles of the Mental Capacity Act 2005. Regulation 11(1) (2)