AKD Care Limited

Bank House Residential Care Home

Inspection report

Gosberton Bank
Gosberton
Spalding
Lincolnshire
PE11 4PB

Tel: 01775840297

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30 June 2017

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Ratings

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

Summary of findings

Overall summary

The inspection took place on 30 June 2017 and was unannounced.

The home provides residential care for up to 30 people. The care provided is for adults of all ages, some of whom experience memory loss and have needs associated with conditions such as dementia. At the time of our inspection there were 18 people living at the home.

There was a registered manager for the home. A registered manager is a person who has registered with the Care Quality Commission 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 carried out an unannounced comprehensive inspection of this home on 21 December 2016. A breach of legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the safe storage and administration of medicines.

We undertook this focused inspection to check that they had followed their plan and to check if they now met legal requirements. 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 Bank House Residential Care Home on our website at www.cqc.org.uk"

At this inspection we found the provider had not made all of the improvements needed to meet the regulations.

Medicines were not kept secure while they were being administered and some medicines were kept in a cabinet in the dining area which was not locked. Medicine details had been handwritten on the Medicine Administration Records (MAR) and no double check had been completed to ensure the information transferred was correct. There was a lack of clarity were the administration of as required (PRN) medicines should be recorded and there was a lack of guidance around the homely remedies people could take. Systems to ensure that there were medicines available for people when needed were not robust and medicines audits had not identified concerns.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

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

Medicines were not kept secure and were not always available for people when needed. Recording of medicines was inconsistent. Audits of medicines had not identified concerns.

Bank House Residential 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 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.

We undertook an unannounced focused inspection of Bank House Residential Care home on 30 June 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 21 December 2017 inspection had been made. The team 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 legal requirements.

The inspection was undertaken by an inspector. During our inspection we spoke with the registered manager and the deputy manager and spent time observing care. We looked at 10 care plans and 17 medicine administration records.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the service.

Requires Improvement

Is the service safe?

Our findings

At our inspection on 21 December 2016 we found that people's medicines were not always safely administered to them. There were some gaps in the recording of medicines on the medication administration record (MAR). Protocols were not always in place to ensure that as required (PRN) medicines were administered consistently by staff. Advice had not always been sought from a pharmacist about the safety and efficacy of each medicine when crushed or hidden in food. Medicines were stored in a cupboard above a radiator and no temperature readings had been taken to check that the level of heat would not affect the medicine stored in the cupboard. This was a breach of regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment. After our inspection the provider wrote and told us what action they would take to ensure medicines were safely administered.

At this inspection we saw that action had been taken to reduce and monitor the temperature that medicines were stored at to ensure they maintained their effectiveness. In addition, the provider had liaised with their medicines provider to change the monitored dosage system in use. This increased the safety of administration as each pot of medicine was individually labelled with the person's name and time and date of administration. However, the member of staff completing the medicines round did not follow good practice guidance around the safe administration of medicines. They removed the pots of medicine for everyone who required lunch time medicines and left these and other medicines in separate packages unsecured while giving people their medicines. In addition, a cupboard which was used to store homely remedies and prescribed medicines for constipation was no locked.

MAR charts had been fully completed for medicines prescribed to be taken on a regular basis and administered on a regular basis. However, seven people had some or all of their MAR chart hand written and these had not been double checked in line with good practice guidelines to ensure that the information had been transcribed appropriately. this increased the risk of people receiving the wrong medicines.

In addition, some medicines prescribed to be taken regularly had been amended by hand on the MAR to be taken as required (PRN). Records showed these medicine had not been administered to people on a regular basis. There was also inconsistent recording of all medicines prescribed to be taken PRN. There was inconsistent recording of why these medicines had been offered to the person, some instances were recorded on the MAR sheet, some on the PRN recording sheet and some on the homely remedies recording sheet. This inconsistent recording increased the risk that medicine error would occur.

People's care plans contained very brief information on people's PRN medicines. For example, one person's care plan recorded they needed a medicine for anxiety and aggression but did not support staff in how to try calm the person without the medicine. Another care plan recorded that a person was to have paracetamol to help when in pain, but no guidance was available to support staff to identify if the person was in pain. People were at risk of not receiving medicines when they required because guidance was not in place.

Records showed that two person had not received one of their medicines for eight days. It was recorded in the MAR chart as not being given for other reasons. We discussed this with the registered manager who told

us that it had not been given as they had not reordered this medicine in a timely fashion and therefore during this period there was none available for the people to take. In both cases this was a medicine to stop the person feeling sick and so they may have had a reduced quality of life while the medicine was not available.

At our last inspection on 21 December 2016 we identified that the registered manager needed to gain advice about crushing medicines from a pharmacist. However, records showed for one person they did not get advice until 19 May 2017, five months after our inspection. The pharmacist advised that one tablet the person was taking could not be crushed as it was toxic. This delay in getting advice had meant that staff and people living at the home had been placed at risk for longer than necessary.

The home had a supply of homely remedies such as pain killers and cough medicines available for people to take for short term minor illnesses. However, there was no record available to show which medicines people could take and which may interact with medicines they were already taking and should not be given without medical advice.

Records showed that there were errors on some of the MAR sheets. For example, one person's medicine had been recorded on the wrong day. Instead of crossing out the incorrect entry and recording why this had been done an arrow had been added pointing to the correct day. On another person's MAR sheet we saw that one medicine had been recorded twice and for 11 days both entries had been completed. We raised this with the registered manager who was unaware that there had been an issue and no investigation had been completed to see why this error occurred.

We raised all the concerns we identified with the registered manager. They were unaware that there were on going issues with the medicines. They had not identified the issues with the unsecured medicines when staff were administering medicines. They were unaware of the concerns we had identified MAR sheets. They told us that medicines audits had been completed on a regular basis and that these concerns had not been identified. Following our inspection the provider contacted us and told us that the member of staff we had observed administering the medicine had now been removed from this role to safeguard the people living at the home.

This was a continuing breach of regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 not ensured that there were sufficient quantities of medicines available for people and medicines were not managed safely. Regulation 12(2)(f)(g)

The enforcement action we took:

We issued warning notices against the provider and the registered manager.