

Laurels Lodge Limited

# Grosvenor Park Care Home

## Inspection report

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Date of inspection visit:  
01 September 2016

Date of publication:  
14 October 2016

### Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

# Summary of findings

## Overall summary

This inspection visit took place on 1 September 2016. This was an unannounced inspection, which meant that the staff and provider did not know that we would be visiting. This was a follow up focussed inspection to look at issues we found on our visit to Grosvenor Park Care Home on 16 March 2016.

Grosvenor Park is a care home that provides up to 61 places for older people, including people living with dementia. It does not provide nursing care. The home is located in Darlington and is close to local amenities and transport links. On the day of our inspection 57 people were using the service.

When we visited the service on the 16 March 2016 we found that medicines were not stored in a consistently safe manner and there was a risk that people were not receiving topical creams as prescribed due to poor record keeping. We also found that incident recording of falls was not consistently in place and this impacted on monitoring and avoiding future incidents.

We issued a requirement notice to the registered manager to send us a report (action plan), within 28 days, to explain how they intended to mitigate the risks of poor medicines storage and falls management and address the breach of regulations. The registered manager sent this report to us promptly and we were satisfied with how they intended to address the issues we found.

There was a registered manager in post. 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.

On this visit we spoke with the registered manager. They explained the checks they carried out to ensure medicines were stored and administered correctly. We saw improvements the service had made around storage, recording and administration of topical medicines.

During the inspection we also saw improvements had been implemented by the registered manager in recording incidents including falls and also how these were monitored and managed to reduce repeat incidents.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe

We saw that medicines were stored, administered and recorded in a safe manner.

Incident recording and monitoring of falls incidents was in place and actions to reduce repeat incidents.

# Grosvenor Park 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 (HCSA) and to review a breach of Regulation 12 in relation to medicines that we found on our visit to the home on.

This inspection took place on 1 September 2016 and was unannounced.

The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed all of the information we held about the service including statutory notifications we had received from the service. Notifications are changes, events or incidents that the provider is legally obliged to send us.

At our visit to the service we spoke with the registered manager, two senior care workers and two care workers. We looked at the storage and administration of medicines, along with the temperature recording system that was in place at the service.

During the inspection we looked at the medicine administration record sheets (MARS) for three people who used the service. We also looked at falls incident recording information, monitoring and risk assessments for three people who used the service and monthly incident monitoring information.

# Is the service safe?

## Our findings

We previously visited the service on 24 March 2016 and carried out a comprehensive rating inspection. We found that medicines were not administered and recorded in a consistently safe manner. There was a risk that people were not receiving their medicines as prescribed due to poor record keeping.

We looked in the room where the medicines were kept and saw the medicine fridge daily temperature record. Although a record was kept daily of the treatment room and fridge temperatures, a number of these recordings were found to be missing. The fridge was also very hot to the touch. This meant that medicines may have been at risk of being compromised as they were not always stored safely.

We also saw that prescribed creams for topical application were not dated on opening or discarded every month. A topical administration chart was not available for creams in people's rooms accessible to care staff to administer. When we asked staff about this they explained that these were going to be put in place. This meant that topical creams were not stored, administered or recorded safely.

Following the comprehensive inspection of 24 March 2016 we issued a requirement notice to the registered manager to send us an action plan, within 28 days, on how they intended to mitigate the risks identified and address the breach in managing medicines safely. The registered manager sent this report to us promptly and we were satisfied with how they intended to address the issues we found.

On this focussed inspection we spoke with the registered manager. They showed us the medication storage and topical medicines administration record sheets (MARS) for three people who used the service. Clear records were kept to show when people had received their medicines. Body maps had been introduced for people receiving prescribed topical creams. This meant staff now had accurate information to help them identify where on a person's body topical creams needed to be applied, reducing the risk of errors.

We looked at the room temperature and fridge temperature records and all were fully completed and within the recommended temperatures. A new fridge had been purchased and was seen in the medicines room.

We saw from looking at meeting minutes and staff communications that the registered manager had carried out discussions via team meetings to discuss the safe administration of medicines and to address the issues including opening dates on topical medicines that were identified at our last inspection.

We were able to see from looking at three people's care records that an updated falls recording section had been added since our last inspection. This section was much clearer and included an updated risk assessment to highlight people who were at risk of falling. Where people had incidents recorded, clear monitoring information was present and this included actions to reduce risks including regular checks on the person for 30 minute intervals for a 24 hour period. When we spoke with the senior care worker they told us, "As well as the monitoring we use our handover to record things because if someone is injured bruising doesn't always come out for 24 hours. Swelling can also happen later so the monitoring covers this. It helps us monitor people after a fall so we know what is happening and if we need to seek more help."

At the time of this inspection there was a moving and handling training session underway for two new care workers delivered by the senior care worker. We were able to observe part of the training session as this related to falls. The senior care worker used role play and questioning with the new care workers to enable them to demonstrate their understanding of the falls procedure and what to do in an emergency. This showed us that the service had taken actions to ensure the falls procedure was understood by staff.