Mr Anthony John Bloom

Devonia House Nursing Home

Inspection report

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Date of inspection visit: 11 November 2015
Date of publication: 13/01/2016

Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Overall summary

A comprehensive inspection of this service was carried in April 2015. We identified nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at that inspection. The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Services placed in special measures will be inspected again within six months.
- The service will be kept under review and if needed could be escalated to urgent enforcement action.

We shared our concerns with the local authority commissioning teams. As a result of concerns identified at the inspection in April 2015 placements to the home had been suspended by Devon County Council or the local Clinical Commissioning Group (CCG).

The provider sent us an action plan following the inspection in April 2015 which stated they would be compliant with the safe management of medicines by 17 August 2015. We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements in relation to the safe management of medicines. Focused inspections evaluate the quality and safety of particular aspects of care. This report only covers our findings in relation to this breach. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Devonia House Nursing Home on our website at www.cqc.org.uk

We will carry out a further unannounced comprehensive inspection to assess whether actions have been taken in

Summary of findings

relation to the other breaches of regulation. This report only covers our findings in relation to the safe management of medicines and we have not changed the ratings since the inspection in April 2015.

We found people's medicines were not managed safely and the planned improvements had not been fully implemented. People had not always received their medicines in the way prescribed for them. There were no systems in place to guide care staff on how to apply creams or other external items and no system to record when these were applied to people. Some medicines were not stored securely or within the guidance of the manufacturer. Staff did not consistently sign the medicine administration records to show people had taken their medicines as prescribed.

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?

Medicines were not managed in a safe way to ensure people were protected from risks associated with unsafe management of medicines.

Inadequate

Devonia House Nursing 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.

This inspection took place on 11 November 2015 and was unannounced. This was a focused unannounced inspection to look at medicines handling in response to concerns found at our previous inspection. This inspection was done to check that improvements to meet legal requirement planned by the provider after our comprehensive inspection in April 2015 had been made. The team inspected the service against one aspect 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 two CQC medicines inspectors.

During the inspection we checked six people's medicines and medicines administration records, and also checked medicines storage systems and policies. We watched some people being given their medicines at lunchtime and spoke with one resident about their medicines. We also spoke with the acting manager.

Inadequate

Is the service safe?

Our findings

At the last comprehensive inspection in April 2015 the provider had not ensured the safe management of medicines. People did not always receive the medicines prescribed for them; medicines were not stored safely and the medicines policy for the service did not provide the necessary guidance for staff to ensure medicines were managed safely.

The provider sent us an action plan following the inspection in April 2015 stating improvements would be made by August 2015.

During this focused inspection we found people's medicines were not managed safely and the planned improvements had not been fully implemented. The pharmacy provided printed medicines administration record sheets for staff to complete when they had given people their medicines. These were not always completed appropriately. For example we found one or more gaps in people's records for five medicines that had been prescribed to be given regularly, where it was not possible to tell whether the dose had been given to people.

We found another person's chart where five doses had been recorded as out of stock, although the medicine had been recorded as being received into the home. This meant it was not possible to be sure that people received their medicines in the way prescribed for them. We found one handwritten chart where there was no record of who had completed the chart, or whether it had been checked. The chart had been written following a hospital discharge but for two of the medicines the instructions had not been fully transcribed to the administration chart correctly. For another medicine the amount of tablets to be given was not clear. This increased the risk of mistakes being made so people would not receive their medicines correctly.

There were no systems in place to guide care staff on how to apply creams or other external items and no system to record when these were applied to people.

At the time of our inspection we were told that it was not possible for people to look after and take all of their own medicines, as there was no safe and lockable storage for them.

Oxygen cylinders were not stored securely or safely to prevent them falling over, and official hazard warning signs were not being displayed where oxygen was being stored and used in the home.

There was a separate refrigerator for medicines needing cold storage. Records were available to show that the temperature range was being recorded daily. However the temperatures recorded were frequently outside of the recommended range. This meant that it was not possible to tell whether these medicines would be safe and effective for people.

There were suitable arrangements for the storage and recording of controlled drugs.

There were non-prescription medicines kept in the home, for occasional use, but one of these medicines had past the expiry date on the container. Three doses had been recorded as having been given to people since the expiry date had passed. There were also three eye preparations found, where more than the recommended 28 day opening period had passed, which appeared to still be in use. This meant that people's medicines were not always suitable to be used.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014