HC-One Limited

Leeming Garth

Inspection report

Leeming Bar
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18 May 2016

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30 June 2016

Ratings

Overall rating for this service	Inspected but not rated
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 30 September 2015. A breach of legal requirements was found and we required that the provider make improvements to ensure the safe management of medicines. The service was given an overall rating of requires improvement. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the safe management of medicines.

We undertook this focused inspection to check that they had followed their plan and to confirm that 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 (location's name) on our website at: www.cqc.org.uk

We carried out this focused inspection on 18 May 2016. This was an unannounced inspection visit and was completed by a specialist pharmacist inspector.

Leeming Garth provides residential and nursing care for up to 55 people, with the service user bands older people, physical disability and younger adults. The registered provider is HC-One Limited. The home is situated in a rural location on the outskirts of the village of Leeming Bar and consists of an old listed building with modern extensions. The accommodation is arranged over two floors with lift access. There are private car parking facilities, gardens and grounds.

The service had a registered manager who was on duty during our inspection. 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 observed medication being administered to people safely. Safe storage arrangements for medicines were also in place.

Improvements had been made to ensure that medicines were administered in a timely way, with medicine rounds being completed to allow safe time periods between medicine administration.

Systems for the management of end of life medicines and oxygen had also been improved, in response to safeguarding investigation findings.

Arrangements were in place for recording the administration of oral medicines, but some improvements were needed in the records relating to medicine stock, medicines prescribed 'as required' or with a choice of doses, and for topical medicines.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. We found that the provider had completed a monthly medication audit which identified similar issues to those we found relating to recording. Staff also completed daily checks of medicine records. However, these checks had not always been effective. For example, because staff had not always notified the registered manager when discrepancies had been identified.

We found a breach of regulation, relating to records and governance. You can see what action we told the provider to take at the back of the full version of the report.

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 safe, but some improvements were required.

Systems were in place for the management of medicines, so that people received their medicines safely and as prescribed.

Records relating to some medicines were incomplete or not up to date and the effectiveness of governance systems relating to medicine records needed to improve.

We could not improve the rating for safe from requires improvement, because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Leeming Garth

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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook this focused inspection of Leeming Garth on 18 May 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 30 September 2015 inspection had been made. The inspection team inspected the service against one of the five questions we ask about services: is the service safe. This was because the service was not meeting some legal requirements.

This focused inspection was completed by a specialist pharmacist inspector and was unannounced.

Before this focused inspection visit we reviewed the information we held about the service. This included the last inspection report, the registered provider's action plan and information we had received from the local authority and clinical commissioning group. For example, the outcome of relevant safeguarding investigations.

During the inspection we looked at the arrangements for the management of medicines. We looked at the medicine administration records and medicines supplies for 12 people and five care plans. We observed medicine administration practice and storage arrangements. We spoke with the registered manager, the regional operations manager, one nurse and one nursing assistant administering medicines.

Requires Improvement

Is the service safe?

Our findings

During our inspection we looked at the arrangements for the management of medicines. There had been concerns previously about the timing of the morning medication round which was not completed until 11.40 hours. This meant that there was the potential risk that people would not get their medicines at the correct and safe time intervals, especially when agency staff [who are less familiar with the service and needs of individuals] were on duty. There had also been safeguarding concerns raised by the local authority and clinical commissioning group about the way one person's end of life medicines had been managed and the way another person's prescribed oxygen had been managed.

Overall, we found that improvements to the issues raised during the last inspection and during safeguarding investigations had been made. People received their prescribed medicines. However, improvements to record keeping and the effective governance of medicines was now needed.

Appropriate arrangements were in place for recording the administration of oral medicines. Staff had signed medicines administration records correctly after people had been given their medicines. When people had not taken their medicines, for example if they refused or did not require them, then a clear reason was recorded. However, for medicines with a variable dose, the records did not always show how much medicine the person had been given at each dose. Some improvements were needed in the records kept when medicines were carried forward from the previous month. We saw that records for the application of creams and ointments by care staff were not fully completed and it was not always possible to confirm that they had been offered to people, or applied regularly. Accurate records of medicine administration need to be available so that staff can monitor what medicines have been given and when further medication needs to be ordered.

We looked at the guidance information kept about medicines prescribed to be administered 'when required'. There were arrangements for recording this information and care and nursing staff could describe how these medicines would be used for individual people. However, we found the guidance information available in people's care records was not always kept up to date and information was missing for some medicines. For example, one person's 'when required' guidance had not been updated when their prescribed medicine was changed. Accurate records help to ensure people are given their 'as required' medicines in a safe, consistent and appropriate way.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. We saw evidence of a monthly audit completed by management and of regular medicine records checks by staff. We found that whilst staff carried out regular checks of medicines records to make sure they were completed properly, these checks had not always identified issues and registered manager was not always notified when discrepancies were identified. These checks need to be effective, to help identify issues quickly, in order to learn and prevent the issues happening again.

This was a breach of Regulation 17 HSCA (RA) Regulations 2014 Good governance.

We saw that since our last inspection the service had employed nursing assistants who were competent at medicine administration. The nursing assistants administered medicines to people receiving residential care and the nurse administered medicines to people receiving nursing care. This meant that the medicine rounds were completed in a more timely way, with all morning medicines administered by 10am on the day of our visit.

We looked at the arrangements in place to ensure people prescribed oxygen therapy or end of life medicines received them safely. For one person on long term oxygen therapy, there was a care plan in place to describe how this would be managed. For another person where oxygen was prescribed when needed, a monitoring form was in place to measure oxygen saturation three times daily and a care plan was in place to inform care staff what action to take if it fell below the required level. We looked at one person who had an end of life care plan in place. Anticipatory medicines were also available for this person to use when needed.

We looked at the current medicines administration record for one person prescribed a medicine with a variable dose, depending on the results of regular blood tests. Written confirmation of the current dose was kept with the person's medicines administration record (MAR) sheet. Care staff were able to check the correct dose to give. Staff had recorded that this medicine had been given correctly. Arrangements were in place for the safe administration of this medicine.

Medicines kept at the home were stored safely. Appropriate checks had taken place on the storage, disposal and receipt of medication. This included daily checks carried out on the temperature of the rooms and refrigerators which stored items of medication. Staff knew the required procedures for managing controlled drugs. We saw that controlled drugs [drugs that have an increased risk of misuse and require additional safeguards] were appropriately stored and signed for when they were administered. Eye drops which had a short shelf life once open were marked with the date of opening. This meant that the home could confirm that they were safe to use.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 17 HSCA RA Regulations 2014 Good governance Effective systems or processes were not in place to monitor and improve the quality and safety of the service. Regulation 17 (1) & (2) (a). Accurate, complete and contemporaneous records were not kept in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17(1) & (2) (c).