Avery Homes RH Limited

Albion Court Care Centre

Inspection report

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Tel: 01215547261

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Ratings

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 1 October 2015. 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 breach.

We undertook this focused inspection on 18 July 2016 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

Albion Court Care Centre provides nursing care to up to 89 people. At the time of our inspection there were 82 people that lived there.

Albion Court Care Centre is required to have a registered manager in post. There was not a registered manager in post at the time of this 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.

People told us that they generally received their medicines at the same time each day but there were occasions when they did not. We saw that people did not always receive their medicines as prescribed because either the medicines were still in the medication trolley or more medicines had been signed as given than were available. Creams were not always stored safely and at the correct temperatures. Records for the application of medicinal skin patches and creams were not consistently completed so that it could not be determined that people's health needs were being appropriately met.

Our inspection showed that insufficient improvements had been made to ensure that there was safe and proper management of medicines and this had resulted in an on-going breach of regulations and we have taken further enforcement actions. You can see what actions we have taken at the end of this 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 not always safe and sufficient improvements had not been made to meet the regulation to ensure people received safe care and treatment.

People had not always received there medicines safely and as prescribed.

People were safe from harm of abuse because systems were in place to protect them but people did not always feel that staff spoke nicely to them.

Albion Court Care Centre

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Albion Court Care Centre on 18 July 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 1 October 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 a legal requirement.

The inspection was undertaken by two inspectors (including a pharmacist inspector) and an expert by experience. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of service. Our expert by experience had experience of using this type of service.

We looked at the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. Notifications are information the provider has to send us by law.

During our inspection we spoke with eight people, the relatives of four people, one member of agency staff, two nurses, the acting manager and deputy manager and a representative of the provider. We observed interactions between people and staff. We looked at the medication records for 14 people, the care records for three people to check they were receiving care as planned and some audit records in respect of the management of safety in the home.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of 1 October 2016 we rated this question as Requires Improvement and there was a breach in the regulation relating to the safe care and treatment of people because people were not always receiving their medicines as prescribed. At this inspection we checked if the required improvements in the management of medicines had been made and generally at whether people were safe.

We found that not sufficient improvements had been made to ensure that people received their medicines as prescribed and safely and there was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We have taken further action in respect of this breach of regulation.

Most people told us that they generally received their medicines at the same time but some people told us there were times when they didn't. One person told us, "I don't get them at the same time every day but most times it's the same. They've missed my tablets more than once. I think the nurse does the best she can." Another person told us, "I don't think they've missed tablets. It's not always the same time of day." A third person said, "Sometimes the night staff can't find the medicines after the day staff have gone off shift."

The pharmacy inspector looked at the medicines administered to 14 people. We found that medicines were not always managed safely.

People living in the home had not always received their medicines as prescribed. For example we found one person had been prescribed a medicine that was to be given three times a day but the records showed that it had been given four times on one day. On the day of the inspection, a morning medicines round finished after midday. This delay meant that a person had to miss their midday medicine as they were given their morning medicine at that time instead.

We found gaps on people's MAR charts. This is when there is no staff signature to record the administration of a medicine or a reason documented to explain why the medicine had not been given. We also saw that on two occasions a medicine had been signed for as being given when it had not. We found the medicine was still in the medicines trolley and therefore the person did not receive their medicine. If medicines are not given as prescribed, a person's healthcare condition may not be well managed.

We found that the recorded amount of some people's medicines was not accurate. This is important to ensure that it is possible to check that people have been given their medicines. We saw one example where a person was prescribed a short course of 28 tablets but the MAR chart had been signed for administration 32 times. This means that there is not an accurate record of when the medicine was given and it means that the person may not have been given their medicine effectively.

We looked at the records for people who were using medicinal skin patches. Records were available that showed where the patches were being applied to the body. However, the patches were not being applied and removed in line with the manufacturer's guidance and the records were not always filled in. This could

result in unnecessary side effects.

Carers applied prescribed creams to people's skin. Although body maps were available to staff to show where the creams should be applied, they were not filled in. We looked at the records for two people who were prescribed creams and saw that these creams were not being used regularly or as prescribed. A person's skin may become dry and sore if creams are not applied as often as the doctor intended.

Most medicines were stored safely in locked trolleys in a locked room. However, some prescribed creams were kept in people's rooms or bathrooms. This means there is no way of knowing if the creams had been stored safely and at the correct temperature and conditions. Medicines that need cold storage were kept in a temperature monitored fridge. Medicines that require extra records and special storage arrangements because of their potential for misuse were stored securely and recorded correctly. Medicines that had a short expiry date once opened were always dated to ensure that staff knew how long the medicines could be used for. Although medicines were stored securely we found that prescribed creams were not.

We saw that although there were some audits in respect of the management of medicines they were not sufficient to ensure that people received their medicines as prescribed and safely.

People and their relatives told us they felt people were safe and they were assisted appropriately and safely by staff. One person told us, "I feel personally very safe."
We saw that people were protected from harm because staff were knowledgeable about the actions to take if they had any concerns. Information we hold about the service showed that the appropriate actions were taken to protect people when issues were brought to the registered manager's attention. We saw that people were assisted safely by staff when using equipment such as hoists and walking frames.

People were generally happy with the staff that supported them but there were areas where improvements could be made. People told us that the staffing levels were inconsistent with occasions when they were not always enough staff available. People told us staff were reasonably responsive to the call bell but that sometimes they had to wait or the buzzer was placed on the wrong side. People told us that some staff were nice but not all the staff spoke nicely with them. One person told us, "The staff mostly talk to me ok, but not always." Another person told us, "Some of them are alright; some are not so good." A third person said, "I don't have any trouble with the nurses but not everyone speaks to me nice." One relative told us that the service had really improved since the new manager had taken over.

We have not re rating this question.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive their medicines safely and as prescribed. Creams were not always stored safely or at the correct temperatures. Records for the administration of creams and medicinal skin patches were not appropriately completed to show safe and accurate administration. Audits did not ensure that people received their medicines safely and as prescribed.

The enforcement action we took:

warning notice