

Heath Cottage Care Home Ltd

# Heath Cottage

## Inspection report

119 Station Road  
Pendlebury, Swinton  
Manchester  
Greater Manchester  
M27 6BU

Tel: 01617941658

Date of inspection visit:  
12 January 2016

Date of publication:  
07 March 2016

## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

# Summary of findings

## Overall summary

This unannounced Focused Inspection was undertaken on the 12 January 2016.

Heath Cottage is a large detached property and provides care and accommodation for up to 28 people. The home does not provide services to people who require nursing care. There is a car park to the side of the building and ramped access to the rear of the property.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

As part of this focused inspection we checked to see that improvements had been implemented by the service in order to meet legal requirements. This report only covers our findings in relation to those requirements. You can read the reports from our last comprehensive inspections, by selecting the 'all reports' link for Heath Cottage on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

We undertook an unannounced comprehensive inspection on the 09 December 2014. During that visit we found that the registered person had not protected people against the risk of associated with the safe management of medication. We undertook a further comprehensive inspection of the service on 04 September 2015. At that inspection we found that the service was still failing to protect people against the risk associated with the safe management of medication.

During our inspection conducted on the 12 January 2016, we checked the medicines and records for eight people. We found that all the records of people we looked at had photographs and their allergies recorded on their medicines records, which reduced the risk of medicines being given to the wrong person or to someone with an allergy and was in line with current guidance.

The MARS (Medicines Administration Record Sheets) had been printed by the community pharmacy, with the exception of a few handwritten MARS. The handwritten MARS had been checked and countersigned by two members of staff to check and confirm the accuracy of them. We found that one person was taking a pain killer to be taken 'when required' with variable doses (one or two tablets), the MAR chart had the number of tablets administered recorded to make it clear what the person had taken.

Controlled drugs (prescription medicines that are controlled under the Misuse of Drugs legislation) were being stored as per legislation, which was an improvement in comparison to when we visited in September 2015. The fridge had also been replaced and temperatures were recorded daily.

We found some medicines were not always given as prescribed by the doctor. Three people were taking medicines that should have been taken before breakfast, however these were given as part of their morning medicines rather than being separate. One person was taking a medicine to thin their blood with a variable

dose, we found that on one day a dose was given that was higher than what the doctor had prescribed. This meant that this person's blood level may have been too high.

We checked the quantity levels recorded by the home for medicines belonging to four people. The quantities recorded for medicines belonging to two people were different to what was in the home; this meant that these medicines could not be fully accounted for.

A person who was self-medicating when we visited previously did not have a lockable drawer or cupboard for their medicines and their room was unlocked. The home had since fitted a lockable medicine locker, however the service user's room was still unlocked and the medicine cupboard had not been locked when we visited. This is contrary to current national guidance and the home was not following their own medicines policy.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, because the registered person had not protected people against the risk of associated with the safe management of medication.

CQC is currently considering their enforcement options in respect of this matter.

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

We always ask the following five questions of services.

### Is the service safe?

The service was not safe. We found that people were still not protected against the risks associated with safe management of medication.

We found some medicines were not always given as prescribed by the doctor.

We could not improve the rating for 'safe' from 'requires improvement' at this time, because to do so required evidence of consistent good practice over time. We also only looked at aspects relating to the breach of regulations, rather than looking at the whole question relating to 'safe.' We will review this during our next planned comprehensive inspection .

**Requires Improvement** ●

# Heath Cottage

## **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 at Heath Cottage on the 12 January 2016. This inspection was undertaken to ensure that improvements that were required to meet legal requirements had been implemented by the service following our last inspection on 04 September 2015.

We inspected the service against one of the five questions we ask about services during an inspection, which were not meeting legal requirements. During this inspection it included, 'Is the service Safe.'

The inspection was undertaken by a Pharmacist Inspector. Before the inspection, we reviewed all the information we held about the home. We reviewed statutory notifications and safeguarding referrals.

We also reviewed the action taken by the provider following our previous inspection, who wrote to us explaining what action the service had taken to meet legal requirements. During the inspection we spoke with the registered manager of the home, two senior members of care staff with responsibility for medicines and the assistant director of the company.

# Is the service safe?

## Our findings

We undertook an unannounced comprehensive inspection on the 09 December 2014. During that visit we found that the registered person had not protected people against the risk of associated with the safe management of medication. That was in breach of 'Old' Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. The service subsequently wrote to us in May 2015, explaining what action they would take in order to meet the requirements of the Regulations around the safe management of medication.

We undertook a further comprehensive inspection of the service on 04 September 2015. Part of our inspection included checking to ensure that improvements had been made in respect of meeting the requirements of the regulations relating to the safe management of medication. At this inspection we found that the service was still failing to protect people against the risk associated with the safe management of medication. This was in breach of Regulation 12 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. Again the service wrote to us in November 2015, explaining what action they would take to address our concerns.

During our inspection conducted on the 12 January 2016, we checked the medicines and records for eight people. We found that all the records of people we looked at had photographs and their allergies recorded on their medicines records, which reduced the risk of medicines being given to the wrong person or to someone with an allergy and was in line with current guidance.

The MARS (Medicines Administration Record Sheets) had been printed by the community pharmacy, with the exception of a few handwritten MARS. The handwritten MARS had been checked and countersigned by two members of staff to check and confirm the accuracy of them. We found that one person was taking a pain killer to be taken 'when required' with variable doses (one or two tablets), the MAR chart had the number of tablets administered recorded to make it clear what the person had taken.

Controlled drugs (prescription medicines that are controlled under the Misuse of Drugs legislation) were being stored as per legislation, which was an improvement in comparison to when we visited in September 2015. The fridge had also been replaced and temperatures were recorded daily.

We found some medicines were not always given as prescribed by the doctor. Three people were taking medicines that should have been taken before breakfast, however these were given as part of their morning medicines rather than being separate. One person was taking a medicine to thin their blood with a variable dose, we found that on one day a dose was given that was higher than what the doctor had prescribed. This meant that this person's blood level may have been too high.

We checked the quantity levels recorded by the home for medicines belonging to four people. The quantities recorded for medicines belonging to two people were different to what was in the home; this meant that these medicines could not be fully accounted for.

A person who was self-medicating when we visited previously did not have a lockable drawer or cupboard for their medicines and their room was unlocked. The home had since fitted a lockable medicine locker, however the service user's room was still unlocked and the medicine cupboard had not been locked when we visited. This is contrary to current national guidance and the home was not following their own medicines policy.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, because the registered person had not protected people against the risk of associated with the safe management of medication.

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<br><br>Because the service had not protected people against the risk of associated with the safe management of medication. |

### **The enforcement action we took:**

CQC have issued a warning notice with conditions to be met by the 25 March 2016.