Four Seasons (No 10) Limited

Lansdowne Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 28 February 2017 at which one breach of legal requirements was found. The registered provider did not manage medicines safely.

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 a focused inspection on 11 July to check that they had followed their plan and met legal requirements.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lansdowne Care Home on our website at www.cqc.org.uk.

Lansdowne Care Home is a service for older people who are in need of nursing care. Lansdowne Care Home provides accommodation to a maximum of ninety-two people some of who may have dementia.

The home has a registered manager. 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 and associated Regulations about how the service is run.

At our focused inspection on 11 July 2017. We judged that the provider had made improvements in medicine management and had now met legal requirements. However we found that improvements were still required in relation to protocols for the administration of medicines disguised in food or drink and the monitoring of fridge temperatures for medicines.

While improvements had been made we have not revised the rating for this key questions; to improve the rating to 'Good' would require a longer term track record of consistent good practice

We will review the ratings for the service at our next comprehensive inspection.

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.

There were improvements in the way that medicines were managed since the last inspection. Topical medicines administration charts to indicate the application of creams and ointments were now in place.

Best interests decision documents around the use of covert medicines administration with involvement from a GP were in place.

Improvements were still required in relation to protocols for the administration of covert medicines and the monitoring of fridge temperatures

Is the service well-led?

Requires Improvement

The service was not always well-led

There were improved audit systems in place for monitoring medicines administration; however these not had not identified the shortfall found during the inspection relating to the topical administration of creams and recording of fridge temperatures.

Lansdowne Care Home

Detailed findings

Background to this inspection

We undertook a focused inspection of Lansdowne Care Home on 11 July 2017. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 28 February 2017 had been made.

We inspected the service against two of the five questions we ask about services: is the service safe and well-led? This is because the service was not meeting legal requirements in relation to the question safe.

The inspection was undertaken by one Care Quality Commission pharmacist inspector.

Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements.

At the visit to the home we spoke with the registered manager, deputy manager and two nurses. We checked medicines storage, medicines administration record (MAR) charts, and medicines supplies for five people.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found that in the Topical Administration Records (TMARs) the directions were unclear or missing completely and creams had not been applied as the directions had stated. We also found that the covert administration of medicines for people that used the service did not have the correct information documented. When medicines are given covertly, it means that they are hidden in food or drink without the knowledge of the person receiving them.

At this inspection, we saw that records were now made on topical medicines administration charts (TMARs) to indicate the application of creams and ointments. The TMARs were produced by nurses, and signed by health care assistants. Body maps accompanying the TMARs were completed correctly. The TMARs that we looked at were signed by two members of staff to indicate that topical preparations had been applied. We saw two examples for one resident when a preparation was written up for application once a day, but staff had administered the creams twice a day.

Some people were receiving their medicines covertly at the time of the inspection. Documentation showed that mental capacity had been assessed prior to the decision to administer medicines covertly. We also saw best interests decision documents around the use of covert medicines administration with involvement from a GP, the next of kin, staff from the care home and the pharmacist. However the information provided by the pharmacist did not explain how the medicines should be disguised in food or drink. We discussed this with The Registered Manager who told us she would work with the pharmacist to ensure that safe protocols were in place.

All the medicines were prescribed by a local GP and were available for people. All medicines were stored in locked medicines trolleys within the clinical rooms. The clinical rooms were locked and only relevant staff had key access.

Staff recorded the ambient room temperatures of the clinical rooms daily. All the temperature readings provided assurance that medicines were stored at the required temperatures to remain effective.

Staff made records of the fridge temperatures daily. On one unit we noticed that the minimum temperature reading was 2°C each day whilst the maximum temperature reading was 8°C every day. When staff were asked to demonstrate how they took fridge temperature readings, they were unable to demonstrate this and showed a lack of understanding.

On a different unit, staff were only recording the current fridge temperatures, and were not making records of the minimum or maximum temperatures, despite the fact that the fridge was a pharmaceutical grade fridge with the facility to do this.

The impact of poor management of fridge temperatures on residents is likely to be minimal due to the medicines that were in the fridge at the time of the inspection..

Controlled drugs (CD) were stored in an appropriate CD cabinet. We saw that stock levels for CDs were checked twice a day by two nurses. When CDs were administered, the CD register was signed by two nurses. We did a random check of a CD during this inspection. The quantity of CDs in stock matched the quantity recorded in the CD register.

Nurses administered medicines and used MAR charts to record this. We looked at five MAR charts during this inspection. They provided assurance that residents were receiving their medicines safely, consistently and as prescribed. The MAR charts were computer generated by the pharmacy that supplied the medicines. Four MAR charts had a photo to assist with the identification of the people receiving medicines. Information on whether people had any allergies was also available.

Requires Improvement

Is the service well-led?

Our findings

We saw that improvements had been made in the quality audit monitoring systems for topical medicines administration. The Registered Manager now had a full list of all the people prescribed topical medicines so that she could quickly see if any doses were missed.

At this inspection, no missed doses were identified; however we saw one example where a cream was applied twice a day instead of once a day. This was not picked up by the medicines audit. We discussed with the Registered Manager and the senior manager for the provider, who told us that the will look into amending the medicines audit questionnaires to ensure any errors regarding topical medicines would be identified.