Golden Age Management Limited

Attwood's Manor Care Home

Inspection report

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Ratings

Is the service safe?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection of this service on 8 July 2015. After that inspection we received concerns in relation to the safe administration of medicines. As a result we undertook a focused inspection to look into those concerns. 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 Attwood's Manor Care Home on our website at www.cqc.org.uk

The inspection took place on 20 November 2015 and was unannounced.

The service provides accommodation for up to 65 people, some of whom are living with dementia. At the time of our inspection 50 people were resident, one of whom was in hospital.

A registered manager was in post but was on a period of planned leave. An interim manager had been in post but had left the service without notice a few days before our inspection visit. 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.

This report specifically focuses on the key area of Safe with regard to how medicines were managed at the service. This included a consideration of the safe ordering, storage, administration, stocktaking and disposal of medicines.

Medicines were not managed safely. People were put at risk.

Medicines were not always made available to people promptly and the service was not proactive in supporting people to access the medicines they needed as soon as they had been prescribed.

Storage of some medicines was not suitable. Some medicines were stored at the incorrect temperature and others were stored chaotically which made it difficult for staff to administer them and increased the risk of an error.

Summary of findings

Errors in the administration of medicines were numerous and some people had received additional doses of medicines and others had failed to receive the medicines they were prescribed. People were placed at risk of harm. Medicines were not administered in a timely way and staff demonstrated a poor understanding of the medicines they were administering.

Where errors had occurred related to the administration of medicines no action had been taken to ensure the person remained well or to reduce the likelihood of further errors in the future. Spot checks of staff practice in the administration of medicines and auditing procedures failed to identify that errors were taking place. Where stocktaking errors had been identified these had not been investigated by the manager or notified to the Care Quality Commission or to the local authority as a safeguarding matter. The lack of good governance was placing people at risk.

Systems designed for the safe disposal of medicines were not robust and did not provide a clear audit trail to demonstrate which medicines, including controlled drugs, had been sent for disposal and when.

We found a breach of regulation related to the management of medicines. You can see the enforcement action we took at the back of this report.

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?

Inadequate 

The service was not safe. People were at risk of harm.

Medicines were not administered safely by staff. Systems for ordering, storing, administering and disposing of medicines were not robust.

Systems designed to monitor the administration of medicines failed to identify the errors which put people at risk.

Attwood's Manor Care 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.

The inspection took place on 20 November 2015 and was unannounced.

The inspection team consisted of two adult social care inspectors.

Before we carried out our inspection we reviewed the information we held about the service. This included the information of concern we had received regarding poor administration of medicines at the service. We also looked at any statutory notifications that had been sent to us. A notification is information about important events which the service is required to send us by law.

We spoke with five people who used the service, three care staff, one senior care staff and the deputy manager.

We reviewed three care plans related to people's medicines, seven medication records and records relating to the auditing of medicines.

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Is the service safe?

Our findings

People told us that they usually got their medicines on time and people felt that pain medication was available to them when they needed it. One person told us, "I don't know what [the tablets] are but they have made me better". Two people commented on medicines not always being in stock. One person said, "It is the pills they get short of". We found that medicines were not always supplied promptly following their prescription by a GP. We noted that one person who used the service had waited several days for some eye drops to be available to treat their eye condition. Another person went without anti-sickness medication between 24 September 2015 and 10 November 2015. We spoke with the deputy manager about this. They told us that the person's anti-sickness medication had been stopped as it was felt not to be suitable for the person. There had been confusion about which medication would replace it. We noted that the service had not been proactive in seeking out a more suitable medication for this person and saw, from the daily notes, that the person had been unwell during the time they did not have any anti-sickness medication. The original medication was resumed at the request of the person's relative and not due to any advocacy or intervention on the part of the service.

We had concerns about the storage of medicines. We found that eye drops were being stored in the medical room which was very warm (consistently recorded at over 25 degrees). This meant that the drops could have been rendered ineffective as they were not stored in line with the manufacturer's instructions which stated they should be stored below 25 degrees.

We observed one senior member of staff administering medicines .We noted that the drugs trolleys were not well organised which meant that the member of staff sometimes took a long time to locate the medicines they needed to administer. This resulted in people receiving their medicines later than they were supposed to. For example we observed that one person who used the service had not received their eye drops at 10.45 even though the documented time should have been 08.00. Another person had their 11.00 medicine administered at 13.20. Staff signed to say that this medicine had been given at 11.00 which was not an accurate record.

This person's care plan stated that medicines should be given at prescribed times because of a specific health condition. We also noted that this member of staff consistently signed the medication administration record (MAR) chart before they had given the people their medicine and they did not always stay to ensure medicine had been taken. We raised this concern with the deputy manager who assured us they would take immediate action.

Information about people's medicines was not always available to guide staff. There were no profiles informing staff what each person's medicines were for and how they liked to take them. Staff knowledge about people's medicines was not good. One senior member of staff told us that a person's beta blocker (for high blood pressure) was a vitamin tablet and their diuretic tablet was a medication for the treatment of cancer. This placed people at risk as staff did not understand the nature of the medicines they were administering or know action to take if medicines were missed or given at the incorrect time.

We also found another senior staff member was unclear about the procedure for administering one person's Warfarin medication. This medication helps to regulate the ability of the blood to clot and should be carefully managed and monitored. The staff member did not understand how much Warfarin the person should receive and they, and other staff, had made errors regarding this medication. This had resulted in the person receiving additional doses of Warfarin. Information about how much Warfarin to give was not clear on the MAR chart and discontinued doses still remained on the MAR chart which was very confusing for staff. This person was placed at preventable harm. Additional information about this person's Warfarin dose was not attached to the person's medication record and was kept in the main office. We asked the deputy manager to address this concern and a clearer process was put in place before we left the service.

We found errors had been made by staff in all the records we looked at. For example we found that one person had failed to receive their antibiotic tablet on three occasions even though staff had signed to confirm they had been administered. Another person had received double doses of a diuretic medicine for a period of eight days as well as an additional dose of a second diuretic medicine, additional angina medicine and an additional beta blocker. This person had also missed a dose of an antibiotic. There were no explanations on the MAR charts as to why these errors had been made or what action, if any, had been

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Is the service safe?

taken in response to the errors. Staff did not appear to have noticed that medicines were not being administered accurately and safely and did not alert senior staff or the manager to any issues they may have found. One MAR chart had the same two medicines manually entered on different pages of the same chart. Staff had not noticed this duplication and had continued to sign both these records for several days. This person was placed at preventable harm.

We found that stock disposal procedures were not robust and large quantities of medication stock was stored in the medication room awaiting disposal. Staff were required to put unwanted medicines into the disposal bins until a registered disposal company could remove them. There was no accurate record of which medications had been placed in the bins as the record book, which staff were supposed to sign and countersign for each medicine, had not been signed by two staff and in most cases had not been signed by any staff member. Drugs, including controlled drugs, were simply listed by name and quantity being disposed. This meant that stock level errors could not be clearly identified as stocktaking information was not accurate. It also meant that the service could not be sure that all medicines had been disposed of safely and correctly.

We found that stock taking audits carried out between 13 October and 3 November 2015 identified many serious issues relating to medicines. These included 22 Co-codomol tablets, which had been signed as having been administered, which were still in stock. We also saw that 2 additional Epilim tablets were recorded as being in stock which meant that these had not been administered as prescribed to treat a person's epilepsy and 24 Paracetamol tablets had been documented as having been administered but remained in stock. This indicated that recording was inaccurate and also that some people had not received their medication as prescribed. No action was recorded in response to these errors and there was no evidence of plans being developed to ensure that further errors did not take place. Errors had not been notified to the Care Quality Commission or to the local authority as a safeguarding matter.

A most recent full audit of the medication procedures carried out on 20 October 2015 stated the service was 'fully compliant' and did not identify any of the issues we found during our inspection. The deputy manager informed us that only senior staff administered medicines and all had received training but they were unable to locate the training records to confirm this. Although the service carried out regular spot checks of staff's ability to administer medicines safely, these checks were not robust as they failed to highlight the issues we found regarding poor staff knowledge of the medicines they were administering and other issues of poor practice. Ineffective auditing and poor governance was placing people at risk of harm.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 The provider failed to ensure the proper and safe management of medicines. Regulation 12 (1) and (2) (g)

The enforcement action we took:
We issued an Urgent Notice of Decision to vary the conditions of the provider's registration.