Bupa Care Homes (AKW) Limited

Heathland Court Care Centre

Inspection report

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22 December 2015

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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 7 July 2015 at which a breach of legal requirement was found. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the safe management of medicines at the home.

We undertook an unannounced focused inspection on the 22 December 2015 to check that they now 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 Heathland Court Care Centre on our website at www.cqc.org.uk

Heathland Court Care Centre provides accommodation for up to 82 people who require personal and nursing care and support. The service specialises in caring for older people living with dementia. At the time of this inspection there were 45 people using the service.

The service is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager on our records left the service in September 2015. We were notified at the time by them and the provider. A new manager has since been appointed and is the process of submitting the appropriate registered manager application to the CQC.

At this inspection we found the provider remained in breach of their legal requirement for safe care and treatment of people through the safe management of medicines. The provider had failed to ensure there were sufficient quantities of prescribed medicines in stock in respect of one of the people using the service. As a result this person did not receive medicines at times they needed them which put them at unnecessary risk of harm to their health and wellbeing.

We also found records of medicines administered had not been properly maintained by staff and we could not be assured that people had received all their medicines when they needed them.

We are taking action against the provider and will report on this when our action is completed.

We found the provider had taken some action to improve the way they managed medicines at the home. People's records now contained guidance for staff on how and when to administer 'as required' medicines, topical creams and ointments. Meetings had been held with the supplying pharmacy to improve the collection and delivery of medicines to the home. Arrangements to check medicines were properly and safely managed had been improved. Audits were carried out monthly by senior staff. In addition senior staff carried out spot checks on records to identify any issues or concerns about people's medicines. However given the issues we identified these checks may not have been as effective as they should have been.

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

We found that action had not been taken to improve the safety of the service.

The provider had not ensured there were sufficient quantities of medicines in stock to safely meet the needs of all of the people using the service.

Records of medicines administered had not been properly maintained by staff so we were not assured people had received all their medicines when they needed them.

Some improvements had been made. Written guidance was available to staff on how and when to administer 'as required' medicines, topical creams and ointments. Collection and delivery arrangements had been improved. A system of audits and checks was in place to identify any issues or concerns about people's medicines.

We have not changed the rating for this key question because the provider was still in breach of a legal requirement.

Heathland Court Care Centre

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 of Heathland Court Care Centre on 22 December 2015. This inspection was completed to check that improvements to meet legal requirements, planned by the provider after our comprehensive inspection on 7 July 2015, had been made. We inspected the service against one of the five questions we ask about services: Is the service safe?

The inspection was undertaken by one 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.

During the inspection we spoke with the manager, the deputy manager, a registered nurse (RGN) and the provider's quality assurance manager. We looked at medicines administration records (MARs) for seven people using the service.

Requires Improvement

Is the service safe?

Our findings

On 7 July 2015 we inspected the service and identified a breach of the regulations with regards to the safe management of medicines. We found the provider in breach of their legal requirement to ensure that people's medicines were available in the necessary quantities at all times. We also identified issues with the recording of medicines that had been administered and a lack of written guidance for staff as to how, when and why 'as required' medicines should be administered.

Following that comprehensive inspection the provider sent us an action plan in September 2015. They told us they had completed all the actions needed to meet the requirements of the regulations.

At this inspection we found the provider had failed to ensure there were sufficient quantities of prescribed medicines in stock in respect of one of the people using the service. We looked at this person's medicines administration record (MAR) and found they had not received four of their prescribed medicines on the day prior our inspection. On the day of our inspection they had not received one of their prescribed medicines. The deputy manager said the reason for this was because their medicines were not in stock. They told us staff had been aware this stock had not been received in the preceding week. However they had not taken the required action to ensure this was received in time for the person to take them when they needed them. This placed this individual at unnecessary risk of harm to their health and wellbeing.

We also found that records of medicines administered had not been properly maintained. For two people using the service we found gaps or inaccurate recording on their MAR, over two days. For example staff had not signed people's MAR to confirm whether people had received their medicines or not. This did not give assurance that in these cases people had received all their medicines when they needed them.

As a result of these issues we found the provider continued to be in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the provider had taken some action to improve the way they managed medicines at the home. People's records now contained detailed guidance for staff on how and when to administer 'as required' medicines, topical creams and ointments. 'As required' medicines are medicines which are only needed in specific situations such as when a person may be experiencing pain.

Following meetings held with the pharmacy that supplied medicines to the home, collection and delivery of these had been improved so that these were received in a timely manner. Arrangements to audit and check medicines at the home had been improved. Audits were carried out monthly by senior staff. In addition senior staff carried out spot checks on records to identify any issues or concerns about people's medicines. However given the issues we identified these checks may not have been as effective as they should have been.

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
Treatment of disease, disorder or injury	We found that action had not been taken to improve the safety of the service. The provider had not ensured there were sufficient quantities of medicines in stock to safely meet the needs of all of the people using the service. Records of medicines administered had not been properly maintained by staff so we were not assured people had received all their medicines when they needed them. Regulation 12 (2) (f) and (g).

The enforcement action we took:

We issued a Warning Notice on 24 December 2015 requiring the Provider to become compliant with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 31 January 2016.