Leyton Healthcare (No. 12) Limited

Delves Court Care Home

Inspection report

2 Walstead Road
Walsall
West Midlands
WS5 4NZ

Tel: 01922722722
Website: www.leytonhealthcare.co.uk

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Ratings

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

Summary of findings

Overall summary

This unannounced inspection took place on 23 March 2016. This was a 'Focused' inspection and this report only covers findings in relation to the warning notice we issued in regards to medicines.

At our last inspection in November 2015 we found the provider was not meeting the legal requirements to ensure people who used the service were protected against the risks associated with the unsafe use and management of medicines. We served a warning notice on the provider for a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A Warning Notice is a formal way we have for telling providers they are not meeting people's needs or the requirements of the law, and that improvement is required. We met with the provider and asked the provider to send us an action plan detailing the improvements they would make.
We asked the provider to ensure action was taken to address the concerns we found by 29 February 2016. At this inspection we checked to see if the provider had made the improvements required.

Delves Court Care Home provides accommodation, nursing and personal care for up to 64 older people who may have dementia. The home has three floors with the first and second floor providing nursing care. The home currently has a registered manager in place. 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.

Although improvements had been made regarding the specific issues raised within the warning notice we found further improvements were needed to manage medicines safely.

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 consistently safe.

Arrangements for medicines had improved. However, some further improvement was needed. The management of medicine stock levels was not effective. Protocols for administering 'as or when required' medicines were not in place.

Delves Court 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.

This inspection took place on 23 March 2016 and was unannounced. The inspection team consisted of one pharmacy inspector. The pharmacy inspector inspected the service against one of the five questions we ask about services: Is the service safe? We only inspected the safety of medicines. This was because the service was not meeting this legal requirement. Before the inspection we looked at the action plan the provider had sent us. This was to address the concerns we found in relation to the administration and management of medicines at our previous inspection in November 2015. We looked at the administration of medicines and records for 16 people who used the service.

Requires Improvement

Is the service safe?

Our findings

During our previous inspection of 4 and 5 November 2015 we found a repeated breach of Regulation 12(2)(g) the proper and safe management of medicines; of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan telling us about the improvements they would be making to ensure people received their medicines safely. At this inspection we found some improvements had been made. When people were prescribed a variable dose of medicine (e.g. "one or two tablets to be taken") it was always clear what dosage the person was given by looking at the records. Nutritional supplements were kept safely in locked metal cabinets that only nurses had access to. Medicine with a short expiry was always dated when opened to ensure medicines were only used for as long as they were safe. However, the service remained in breach of Regulation 12 and further improvements were needed.

There were adequate supplies of people's medicines in the home to enable people to have their medicines when they needed them. However, some people did not always get their medicines as prescribed. We also found the recorded amount of some people's medicines was not accurate. For example, three people's records showed the medicine in stock was more than what was recorded on their MAR chart. These medicines could not be fully accounted for by staff which meant that we could not ensure these people had been given their medicines as prescribed.

When people had an analgesic skin patch applied to their body to relieve pain, there were no records of where the patches were being applied. This means that staff would have to rely on their memory to know where the patch can be applied safely as the patches cannot be applied to the same site for up to four weeks. There was no way of ensuring the patches had been applied in accordance with the manufacturer's instructions. This meant there was a risk that people's pain would not be well controlled and could lead to unnecessary side effects.

Where people needed to have their medicines administered directly into their stomach through a tube, the necessary safeguards were not were in place to administer these medicines safely. For example, where tablets needed to be crushed to be given via the tube, there was no information on how much water to dissolve the tablet in or if the tube needed to be flushed with water after. There were no written protocols in place to inform staff on how to prepare and administer these medicines and there was no information from the GP to confirm that it was safe to give medicines in this way. There was serious risk that people's health and welfare could be affected because if staff do not have the information needed to administer these medicines safely, it could lead to a blockage of the tube and not enough medicine reaching the person.

One person required drops to be administered to their eye. We found there was no information available to indicate when they should be applied, and to which eye. We saw the person had to stop a member of staff from administering drops into the wrong eye. We spoke with a member of staff about this and they said if it was not specified on the prescription or the MAR chart which eye to put a drop in, then it would be put in to both eyes. This increases the risk that people are having more medicine than they need which could lead to unnecessary and unsafe side effects.

Some people received their medicines "as directed". We looked at the guidance available to staff about the medicines to be administered 'when required' or 'as directed'. We found this information was missing for most of these medicines. One person had a cream prescribed for pain to be applied "as directed". We asked a nurse where it would be applied and we were told that the "nurses knew where the pain was". Because the full instructions were not recorded anywhere, there was a risk that all staff did not have enough information about what medicines were prescribed for and how to safely administer them. It also meant that people may not get their medicines in a consistent way that met their individual health needs.

Where people required creams and ointments to be applied to their skin by staff; we found there was no record made so it was not possible to tell if they had been offered to people or applied regularly. We also found creams that had been prescribed "as directed" or "when required" had no supporting information to inform staff when or where they should be applied. We spoke to one person who told us that staff applied their cream when required. However, there was no record to assure us that people who could not communicate verbally were having their creams applied as prescribed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use the service were not protected against the risks associated with the unsafe use and management of medicines, by means of appropriate arrangements for recording, handling, using, safe-keeping, dispensing and safe administration of medicines.