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Acacia Lodge - London

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service caring?	**Inadequate**

Overall summary

We carried out an unannounced inspection on 12 August 2015 to follow up on warning notices issued to the provider in June 2015 for a continued breach of Regulations relating to care records kept and maintained for people who used the service and management of medicines. Records were not always up to date following a change in people's needs, and medicines were not managed safely. This put people at risk of receiving inappropriate or unsafe care and treatment. We served two Warning Notices for Regulations 12 (1)(2)(f)(g) and 17(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was required to become compliant by 31 July 2015.

At our last inspection in May 2015 we found care plans had not been reviewed and there was inconsistent information pertaining to people's care needs. People's Malnutrition Universal Screening Tool (MUST) assessments were inaccurate because information about people's weight had not been recorded, therefore people had their nutritional needs incorrectly documented. We also found medicines were not managed, stored and administered safely. In May 2015 the overall rating for this provider was rated as 'Inadequate'. This means that it has been placed into 'Special measures'.

During this inspection we found that the provider had made some improvements. We found appropriate systems in place to safely manage, store and dispose of medicines. People received their medicines as prescribed. We noted that the medicine room was tidy and organised.

We saw improvements to the way records for people at the service were maintained. MUST assessments were correctly calculated and people's height and weight correctly recorded. However, we noted that further improvements were required to ensure that all care records were accurate and up to date.

Summary of findings

While overall improvements had been made we have not revised the rating for the key questions relating to safe and caring as this would require a longer term track record of consistent good practice and other breaches of legal requirements identified in May 2015 inspection would need to be met. We will undertake another unannounced comprehensive inspection to check on all outstanding legal breaches for this service and to ensure that the improvements found at this inspection are sustained.

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

We found that action had been taken to improve safety at the service.

Medicines were safely stored and administered. People received their medicines as prescribed.

We could not improve the rating for 'Is the service safe?' from inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

We will review our rating for safe at the next comprehensive inspection

Is the service caring?

Inadequate

We found that some action had been taken to improve care? at the service.

People had their MUST scores accurately assessed, however further improvements were required to ensure all care records were accurate and up to date.

We could not improve the rating for 'Is the service caring?' from inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

We will review our rating for caring at the next comprehensive inspection

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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 the service on 12 August 2015. This inspection was carried out to check that the provider had addressed the legal requirements of warning notices served in June 2015 for breaches of regulations relating to medicines management and records for people who used the service.

The inspection team consisted of an inspector, inspection manager and pharmacist inspector. The team inspected the service against two of the five questions we asked about the service: Is the service safe? and Is the service caring?

Before the inspection we reviewed information we held about the service in our records. This included information about safeguarding alerts and notifications of important events at the service. We also spoke to the local authority quality team who worked closely with the service to improve the quality of the service.

We reviewed care records for eight people who used the service, 20 people's medicines administration records, and spoke with five staff, including the acting manager, the provider, senior care workers and care workers.

Inadequate

Is the service safe?

Our findings

At our last inspection in May 2015 we found medicines were not managed safely because the service was not following current and relevant medicines guidance. We found issues with how medicines were stored, used and recorded. Creams prescribed for external use were stored in open access, this put people at risk of administering medicines not prescribed. Staff administering medicines had received medicines training, however, we judged that this training was not adequate because of the issues with medicines that we found. Medicines audits were not effective as the issues we noted had not been identified prior to our inspection. Therefore we were not assured that safe and effective systems were in place to ensure that people consistently received their medicines safely as prescribed, because of this we served a warning notice.

During this inspection we found that the provider had made improvements to the way they managed medicines. We looked at the service's medicine policies and procedures. These were current and covered all aspects of managing medicines safely. We noted that these included a key policy, procedure for managing medicines for people who went on leave from the service, managing medicines errors, for covert administration, and for giving medicines as required.

We reviewed how medicines were stored. There were designated keys for the medicines room and cupboards and these were held by the person in charge. The room where medicines were stored was clean and tidy. Fridge and room temperatures were recorded daily and were within the required temperature ranges to maintain the effectiveness of medicines. On the day of our inspection we saw that the room temperature was 26 degrees centigrade at 8am. Staff had recorded that they had told the manager and switched on a separate fan. The temperature rose to 27 degrees and we observed that the maintenance engineer was called. The temperature dropped to 21 degrees, within the effective range, by the end of our inspection.

Controlled drugs were secure and records were accurate. Waste medicines were recorded when they were returned to the supplying pharmacist. All eye drops had the date of opening written on the label and none had expired. We saw on the locked medicines trolley that creams and external preparations were kept on the bottom shelf. We saw none in the person's room we looked at. All people had a body map so that a care worker knew where to apply the cream and record accordingly. The site of application of a patch was also recorded.

We observed that the service used a yellow sharps bin for disposal of clinical waste. We saw that a first aid kit was in place. We saw no household or homely remedies.

We looked at the medicines administration records of 20 people. We saw no omissions in recording administration and when someone went on leave the appropriate endorsement was used. All people had their allergy status recorded. We audited 20 supplies of medicines that were not in the monitored dosage system. All apart from one could be reconciled with the records of receipts and administration of stock. For one antibiotic there was one too many tablets in stock which suggested that one dose was not given but signed as given. All medicines in the monitored dosage systems were noted to have been given and signed for.

For two other medicines we were not able to carry out an audit because care workers had not recorded the receipt of a balance of stock carried forward from a previous medicines cycle. For one person who went on leave we saw that care workers recorded what medicines they sent home with the person but not the quantity of boxed medicines sent and returned. This meant that it was not possible to carry out an accurate check of administration of this person.

When a PRN (as required) medicine was given we saw that the reason for giving the medicine was recorded on the back of medicines administration record. There was no individual protocol in place so that all care workers knew how much, how often and the circumstances that the medicines should be given. We were shown a sample template at the time of the inspection and told that all PRN protocols would be put in place by September 2015.

We saw that the anticoagulant warfarin was given to people as prescribed. The service kept the most recent blood test and the result with the medicines record so that care workers could check the latest dose that was prescribed to be given. We found that records of administration of warfarin were accurate. A copy of the

Inadequate

Is the service safe?

local trust policy for managing anticoagulation in the community was kept in a care plan we viewed for a person prescribed warfarin. This detailed possible adverse effects of warfarin therapy and signs and symptoms to look for.

One person was using their own inhalers and there was evidence that the GP had agreed that they were able to. However, this person's care plan was contradictory as it said that the person was compliant but forgets to take their medicines.

Nine care workers received medicines training in June 2015. This covered the management of errors, routes of administration, dosages, safe storage and disposal, and the service's policies and procedures. We saw no hard copy of a British National Formulary of medicines but were told that access could be obtained online. Copies of Patient Information leaflets of all prescribed medicines were kept in the trolley but were not easily available for quick reference to the usage of medicines and possible side effects.

Inadequate

Is the service caring?

Our findings

At our inspection in May 2014 we found that the provider was in breach of standards relating to records. We found records relating to people using the service were not accurate and up to date. Care plans and risk assessments were not updated following a change in people's needs. At our last inspection in May 2015 we found care plans had not been reviewed and there was inconsistent information pertaining to people's care needs. People's Malnutrition Universal Screening Tool (MUST) assessments were incorrectly calculated because information about people's weight had not been recorded, therefore people at risk of malnutrition had their nutritional needs incorrectly documented. This put them at risk of inappropriate and unsafe care because of this we served a warning notice.

We carried out this inspection to check compliance against the warning notice. We found that although there had been some progress, further improvements were needed to ensure records relating to people who used the service were accurate and up to date. We reviewed records relating to MUST scores and saw that five out of six of these were accurately calculated and up to date. The acting manager told us that she was responsible for calculating MUST scores and clarified the incorrectly recorded height in one care plan by providing the correct height recorded in the person's care records. Staff did not complete MUST scores as further training was needed to ensure that these were understood by staff. Staff confirmed that although they had no involvement in completing MUST assessments, they were responsible for monitoring people's weight and reporting any changes or concerns to the senior in charge or the manager.

We spoke with the local authority quality team who told us that they were concerned about the quality of care plans at the home. We reviewed care files for two people who required support with continence, but we were unable to check that continence care plans had been updated to reflect people's needs following the warning notice. The acting manager told us that several documents were missing during the review of people's care files due to changes made by two recently appointed managers whilst the acting manager was on leave. The acting manager and provider told us that they were in the process of reviewing people's files to ensure that these were up to date. We saw an action plan produced by the acting manager which showed that a new person centred care plan is being implemented and would be completed by 30 September 2015.

We observed that there was no care plan or seizure chart for one person who was prescribed medicines for epilepsy. This person had had a seizure in 2015 which was recorded in the medical notes. We found a general information sheet for staff about seizures but this did not provide information on what staff should do to provide care and treatment to this person, which failed to demonstrate the effective maintenance of a complete and accurate care plan for this person.

For a fourth person we found that although their care records included information about type one and two diabetes, this had not been personalised in their care plan to reflect their individual needs as the information regarding type two diabetes was not relevant to them.

For another person we found conflicting information about their needs. In their care plan dated 14 July 2015, one section stated 'walks with Zimmerframe, support of carer at all times.' The personal safety and risk assessment section stated 'I walk independently with support from carer' and that the person was at risk of falls, but we found no risk assessment on file for the management and prevention of falls. Therefore this person may have been put at risk of unsafe or inappropriate care.

The manager told us that care records had gone missing from people's files and that she was currently in the process of reviewing care records for people who used the service. However, we were not assured that governance systems at the service were ensuring the effective maintenance of accurate and complete records about people using the service.