Lifestyle Care Management Ltd

Derwent Lodge Care Centre

Inspection report

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Ratings

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 17, 18 and 19 January 2017. During this inspection we found people were not always protected against the risks associated with the inappropriate management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After that inspection, concerns were raised with us about the way the service ordered and looked after people's medicines and the use of thickening agents in people's drinks.

We undertook a focused inspection on the 9 May 2017 to check how medicines were looked after. 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 'Derwent Lodge Care Centre' on our website at www.cqc.org.uk

Derwent Lodge Care Centre provides nursing care for up to 62 people. There are three floors and the units offer nursing care for older people including those with dementia care needs and people with physical disability needs. At the time of inspection there were 40 people using the service.

The service is required to have a registered manager. 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 legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager had left the service in January 2017 and an interim manager was in post at the time of this inspection.

The provider had appropriate processes in place for the ordering of medicines.

Systems were in place for the safe administration of medicines.

Medicines were stored safely and securely.

We have made a recommendation about reviewing and learning from medicines incidents.

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 improvements had been made in relation to medicines and that medicines were being looked after safely.

The provider had appropriate processes in place for the ordering of medicines.

Systems were in place for the safe administration of medicines.

Medicines were stored safely and securely.

The rating for this domain is unchanged. We need to see sustained improvement in the management of medicines and there was a breach of a second regulation for this domain found at the previous inspection which has not yet been reviewed.

Derwent Lodge 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 was 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 carried out an unannounced comprehensive inspection of this service on 17, 18, 19 January 2017. Four breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements. They stated they would meet legal requirements in relation to the safe management of medicines by 18 April 2017. Following that inspection, concerns were raised with us about the way the service ordered and looked after people's medicines and the use of thickening agents in people's drinks.

We undertook this unannounced focused inspection on 9 May 2017 to check that the service had followed their plan to address the medicines shortfalls from the comprehensive inspection and also to review the medicines in light of the concerns that had been raised since that inspection. This report only covers our findings in relation to this topic.

The inspection was undertaken by one medicines inspector.

Before our inspection we reviewed all the information about concerns relating to medicines that had been received by the Care Quality Commission since the last inspection.

At the inspection on 9 May 2017, we spoke to the support manager, five nurses and one member of the care staff. We looked at the arrangements for ordering, storing, and administering medicines. We looked at 26 medicines administration records started on 8 May 2017 and 16 from the previous month. We also saw the application records for three people's creams and ointments and four people's care records relating to their medicines. We saw five recent medicines audits carried out by staff and three medicines error reports.

Inadequate

Is the service safe?

Our findings

At the inspection on 17,18 and 19 January 2017 we found that people were not always protected against the risks associated with the inappropriate management of medicines. Specifically we found discrepancies in people's medication administration records (MARs) on the first 2 days of the month which meant we could not be assured that people were receiving their medicines as prescribed. We also saw that some people's medicines had been ordered to be given crushed to enable them to swallow them more easily, even though the particular medicines were not suitable for crushing and alternative formulations were available. During this inspection we found that improvements had been made. Following our inspection in January 2017 we received concerns about the way the service ordered and looked after people's medicines and the use of thickening agents to help people swallow drinks. During this inspection we found that these were being managed safely in the service.

Suitable arrangements were in place for ordering people's medicines. Staff told us they checked the medicines received with the medicines administration records (MARs) and a copy of their order, to make sure the correct medicine were supplied. Records showed that people's medicines were available for them. No medicines were being crushed. We saw that where people needed additional support to swallow their medicines they were prescribed suitable forms such as liquids or dispersible. The service had information from the Clinical Commissioning Group (CCG) pharmacist to support their use of these medicines.

Staff told us that no one currently living in the service looked after their own medicines. Medicines were given by qualified nurses, who were trained to do this. We saw the nurse giving one person their lunch time medicines in a safe and kindly way.

The pharmacy provided printed MARs for staff to complete when people had taken their medicines. Staff had completed records clearly and fully, which helped to assure us that people had received their medicines as prescribed for them. Medicines we checked were correct and showed that they had been given as prescribed.

The service received their medicines in standard packs and kept a daily running total of the stock balance. This helped staff assure themselves that people had received their medicines as recorded. It also helped staff to identify when supplies were running low and needed to be reordered.

Staff told us they had started a system of checking each other's MARs each day so they could quickly identify any gaps or discrepancies and take appropriate action. There was no formal record of these checks.

Some people were prescribed a medicine for a particular medical condition, this had a variable dose depending on the results of blood tests. We saw the results of the most recent blood test and current dose with people's MARs. Additional records were kept of the administration of these tablets and the running stock balance. This meant staff could check this medicine had been given safely and correctly.

Some people needed a thickening agent to be added to their drinks to help them swallowing and reduce the

risk of choking. We saw that people had their own labelled supply of this product. Information about how much to use and the consistency needed for each person was available in people's rooms, in the satellite kitchens where staff prepared people's drinks and in the nurses office. This helped to ensure that staff giving people drinks had the information to make these to the safe consistency.

Staff told us that information about use of thickening agents was also available on the nurses handover sheets so they could see how to give people their medicines safely. However, we saw that the information on this sheet was incorrect for one person which could increase the risk of staff using the wrong consistency of liquid, if they did not know the person. We saw that the liquid was made to the correct consistency and the error was corrected at the time of inspection.

Medicines were stored securely in locked medicines cupboards within a locked clinic room. Each floor had a medicines refrigerator. Staff checked the temperature of the refrigerators twice daily. Records showed that these were in the safe range for storing medicines. Suitable arrangements were in place for storing and recording medicines that needed additional security. This helped to ensure that people's medicines were looked after safely and available for them.

We saw five recent medicines audits carried out by staff. This helped staff to assure themselves medicines were looked after safely. We saw three reports of medicines discrepancies but it was not clear from these whether action had been taken to establish if the medicine had been given correctly and to prevent similar errors occurring.

We recommend that the service consider current guidance on identifying, reporting, reviewing and learning from medicines errors and take action to update their practice accordingly.