Plymouth Age Concern

Patricia Venton House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 22, 29 and 31 March and 2 April 2016. Breaches of legal requirements were found and enforcement action was taken.
After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to Safe care and treatment and Good governance.

This was because people's medicines were not always managed safely or properly. There were gaps in Medication Administration Records (MAR) where staff had not signed to show that medicines had been given. People who had declined medicines did not have the reason for this documented to ensure any resultant needs were monitored. Information recorded in the MAR charts was conflicting. MAR charts in use had some hand-written changes. These changes had not been rechecked, including the strength of medicines prescribed, to ensure they were accurate. A record of the temperature for the fridge used to store medicines was not always completed.

Systems were not in place to review infection control practices. Infection control procedures were not always updated as required to ensure service users were protected from the possibility of cross infection. Not all staff had undertaken training in infection control.

Systems and processes were not in place to identify and assess risks to the health, safety and welfare of people who used the service. Some people had risk assessments but these were not updated or were an accurate reflection of people's needs. Some people did not have a risk assessment in place. There was no clear link between risk assessment and care planning. Some people's risk assessments were not factually correct.

There were no systems or processes in place to ensure there were sufficient staff to meet the needs of people using the service. There were no assessments of people's level of dependency or learning from audits of falls and call bells, to help establish the required number of staff to meet peoples' needs.

Accurate, complete and contemporaneous records were not kept to ensure the service had sufficient information to meet people's needs. Systems and processes were not in place to update people's assessments following changes in their health. Records gave conflicting information about people's health needs. Visits by health care professionals were not always documented in the correct section of the care records. Changes to people's care plans following medical advice or changes to their health and well-being were not completed. Records of the care and treatment provided to people and decisions taken in relation to the care and treatment provided were absent.

After the comprehensive inspection the provider submitted an action plan, to tell us what they would do to meet the legal requirements in relation to the breaches. We undertook this focused inspection on 6 September 2016 to check improvements had been made. Included in this action plan was the following statement; "We have also engaged an independent, external consultant who will be offering guidance and

support in the areas of quality and compliance, who will also be undertaking monthly visits to the service to monitor progress and will be reporting back (to the Board)."

Patricia Venton house provides accommodation for up to 25 people who require support with their personal care. The service mainly provides support for older people who may be living with dementia. There were 14 people living at the service at the time of our inspection.

The service has been without a registered manager since May 2015. 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 and associated Regulations about how the service is run.

The provider/trustees of Patricia Venton House had employed a manager to run the service locally. The manager intended to register with us. The action plan stated; "We have employed a suitably qualified and experienced manager who plans to make an application to register with the CQC on completion of her probationary period."

At this inspection we found people's medicines were not always managed and administered safely. The service had started a new system for the administration of medicines. Records of the amount of medicines held for each individual were not all correct. One medicine was not held in the original package. Changes to people's medicines recorded onto a MAR (Medication Administration Record) were not signed by two members of staff as required. A faxed confirmation sent to the service from the GP stating when a change in medicines was required, had not been completed with sufficient detail. For example, confirmation that the service had added the change of medicines to the MAR. This meant it was possible that information was recorded incorrectly and might lead to a medicines error.

Staff who administered medicines had received up to date training and their competency checked. People's care plans showed some areas of improvement. An external auditor had been employed to advise in the updating of all care records. However, some improvements were needed to meet the requirements of the warning notice. For example, some care records still had hand written changes and suggestions made by the auditor. All risk assessments were not yet completed.

Systems and processes were in place to update people's assessments following changes in their health.

There were sufficient staff to meet the current number of people living in the service. Staff had completed training from the local pharmacist and were in the process of completing accredited training. Staff had also received infection control training.

Clear infection policies and practices had been introduced. Audits of infection control had taken place. Most staff had received training in infection control.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we told the provider to take at the back of the full version of this report.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (Patricia Venton House) on our website at www.cqc.org.uk."

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

Action had been taken to make improvements. However some improvements were still required to meet the legal requirements.

People's medicines were not always managed, recorded and administered safely and further action was being taken to help ensure documentation was accurate.

People were mostly protected from risks associated with their care and documentation relating to this reflected people's individual needs. However some improvements were still required.

There were enough staff to meet people's needs.

We could not improve the rating for Safe from Requires Improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

Action had been taken to make improvements. However some improvements were still required to meet the legal requirements.

Systems had and were continuing to be devised and implemented to help ensure the quality of the service people received was effective and meet their needs.

Auditing systems helped to highlight areas which required action and drive continuous improvement across the service. However further auditing was required in particular on medicines.

We could not improve the rating for Well-led from Requires Improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Patricia Venton House

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 focused inspection was undertaken by one inspector on the 6 September 2016 and was unannounced. This inspection was carried out to check that improvements to meet legal requirements after our comprehensive inspection on 22, 29 and 31 March and 2 April 2016 had been made. We inspected the service against two of the five questions we ask about services: is the service safe and is the service well led? This is because the previous breaches were in relation to these two questions.

Prior to the inspection we reviewed the information held by us including the information sent to us by the registered provider in response to the warning notices. We also looked at previous inspection reports.

During the inspection we looked at the care of four people in detail to check they were receiving their care as planned. We spoke with the manager and two senior staff members about their infection control training. We also looked at the medicines records for five people in the service and the audits for medicines and care plans.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 22, 29 and 31 March and 2 April 2016 medicines were not being managed safely, there were not enough staff to meet people's needs and individual risk assessments were not in place for people to ensure care was provided safely. Infection control procedures did not always ensure people were protected. There was a lack of documentation on people's records to assist staff to meet people's needs. We found recording GP or other health professional advice in different places and people's eating and drinking plans were not all in place to help keep people safe. We found pre-admission assessments were incomplete or lacked detail. Initial assessments of people's health and welfare were not always completed. People did not have plans in place that addressed their specific diagnosis. Daily handover notes and records of how staff met people's needs were not always completed as directed or they held information which conflicted with other records. People had a "This is me" record in their care plan and these were found to be inconsistently completed with conflicting information which could place people at risk. At this inspection, we found the manager had taken some action to address these shortfalls but further action was needed in relation to medicines management and the completion of risk assessments and updating of all care plans.

At the previous inspection people's medicines were not always managed and administered safely. Information received from other healthcare professionals, including the GP, was not always recorded clearly or acted upon. Medicines received mid-month had not all been checked in by two people as required by the service's own medicine policy and procedure. This meant it was possible that information may have been recorded incorrectly and led to, for example the wrong dose being administered.

At the previous inspection there were gaps in people's medicine administration records (MAR) sheets when people refused medicines. The reason for refusal was not always documented. Information about people's allergies was not always recorded. People who had their medicines given covertly (without their knowledge) in their food had not been assessed in line with the Mental Capacity Act 2005 and there was no recorded evidence of a best interests meeting where this decision had been made. Skin creams applied were recorded in people's daily notes but MAR charts were not completed for these prescribed medicines. There were no body maps in place to show which area of the body the cream should be applied, the frequency or the amount of application. Temperatures of fridges were not recorded daily to ensure medicines remained at a safe temperature. This meant people may not have always received their medicines safely.

At this inspection we discussed with the manager what improvements had been made to meet legal requirements in relation to Safe care and treatment and Good Governance.

After the previous inspection the manager had a meeting with the local pharmacist to look at the system in use. The pharmacist had sent the manager a full report outlining how they could be managing medication better with full training given to staff. The report included looking at each issues raised by us at the previous inspection with an action recorded by the pharmacist. For example, a recording template on the back of a MAR chart would be explained at the training event. This template could be used at all times to ensure that all declined medicines had a reason recorded.

A new medicines system was implemented following the last inspection due to errors found during checking of the previous system.

At this inspection we found MAR charts showed the service had reordered next month's medicines. There was no audit of the number of medicines held before reordering which meant excess stock may be held. The new system had started without recording and including a baseline on the total number of medicines held at the service. For example, the MAR recorded that 28 tablets were received and the staff did not add to this the number of tablets already held in the stock cupboard.

Therefore records of the amount of medicines held were not all correct. For example, one person was prescribed a 50 microgram dose tablet and a 25 microgram dose tablet. The amount left should be 17 tablets of both the 25 microgram and the 50 microgram. However on counting the number remaining it was found that the 25 microgram tablet had 19 tablets and the 50 microgram tablet had 15 tablets. This meant this person could have received the wrong dose of medicine.

One medicine patch was not held in the original package and found loose in one person's container. During the inspection we asked the staff assisting us and manager to locate the original box, however they were unable to at that time. This meant staff could not check the pharmacist label or if it was labelled correctly for the right person and the correct dose. Not having the original box meant this was classed as secondary dispensing. The implications are that the patch could be accidentally placed into another person's container and there would be no way of telling (apart from the MAR sheet) who the patch was intended for. This could lead to confusion or the person receiving incorrect treatment.

Changes to people's medicines recorded onto a MAR were not signed by two members of staff as required. A faxed confirmation sent to the service from the GP stating when a change in medicines was required, had not been completed as required.

Some medicines risk assessments in care plans had been updated while others had hand written details to assist the staff with updating records. The service was developing a "Medical Profile" for each person. A completed medical profile included current medicines, dosage and times for administration as well as any allergies. However one form was not photocopied clearly and the headings for each section were not legible. This meant staff were not highlighted to the person's allergy.

Not ensuring the proper and safe management of medicines for people is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we saw some changes and improvements had been made to the way medicines were managed. For example, the service had introduced a new system for the dispensing of medicines. The manager said this new system would help reduce errors and with staff trained it would further reduce errors. The service had worked closely with the local pharmacist in setting up this system including providing training for the staff on the administration of medicines using this new system.

MAR charts showed no gaps as all administered medicines had been signed for. The service had introduced a new form if people refused medicines. This recorded why this person had refused the medicine and the action taken, for example contacting the GP for advice.

Following our feedback to the manager, they arranged an emergency meeting involving all staff who administered medicines, the pharmacist and the pharmacist dispensing technician to help resolve these issues. However minutes recorded at the emergency meeting held with the pharmacist, dispensing

technician, manager and staff said; "It was agreed that some human error in administration may have occurred."

The minutes of the meeting went onto say that a full inventory of medicines would take place and all MAR charts be amended to zero in order to obtain a correct baseline ensuring a true audit. The manager would also undertake weekly medicine audit until further notice.

One person was currently receiving covert medicines (without their knowledge). For example one person received their medicine in jam and the reasons for this were clearly documented. Their file held information on the best interests agreement involving the GP and was supported by a risk assessment.

Prescribed creams were recorded onto people's MAR and supported by a body map indicating where the cream was to be administered.

The service had purchased a new fridge and temperatures had been taken most days. The recording of temperatures had been missed for three days in August. The staff said agency staff had covered those shifts.

At this inspection we discussed with the manager what improvements had been made with regard to the lack of documentation on people's records found at the previous inspection to assist staff to meet people's needs.

We found at this inspection, people's care records were in the process of being updated. For example, one person's records regarding how their health care needs should be met had been updated; but updates to other areas of their care plan were still required. The service had employed an external auditor to assist with this process. The manager had updated some care records. Others had been passed to the external auditor who had made additional recommendations to ensure all care records had sufficient information to meet people's needs safely. The manager was in the process of making these changes.

People's care records and daily notes recorded when a person had been referred to a specialist for advice. One showed a district nurse visiting to change dressings, while another held incorrect information, because staff had recorded the information on the wrong record.

Some people had completed risk assessments in place in relation to their risk of falling, manual handling, skin care (Waterlow) and nutritional needs (Malnutrition Universal Screening Tool; 'MUST'). People's food and fluid intake monitoring forms were completed to help ensure people received sufficient food and drink to maintain their health. Other care files showed they were in the process of being updated with hand written details showing staff what needed reassessing and updating. One person had a risk assessment in place to monitor their diabetes and blood glucose sugar levels. There was a protocol in place to show staff how often the blood glucose levels should be taken and what to do if they were too low. However it did not show what staff needed to do if they were too high. The protocol stated the blood glucose levels should be taken every morning. The chart showed days missed or the test taken later in the day. The manager discussed this issue with the staff who confirmed they were not always able to obtain blood to test this person's blood glucose levels due to the person's age and general health. The manager spoke to the pharmacist and a new system was implemented to help ensure this person's blood glucose levels where checked.

An accurate, complete and contemporaneous record for each person was not maintained. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not had any new admissions since the last inspection. However, the manager was in the process of updating all respite people's care records. This included updating pre-admission assessments to assist the service in deciding if they were able to meet individuals' needs safely.

No one was currently on respite care. However one care plan for someone due in for respite care showed updates were underway. This included hand written prompts to update risk assessments, personal care details and the completion of a pre-admission assessment to assess if the service was still able to meet this person's need.

Another person who had a diagnosis of dementia now had this information recorded into their care plan. Information was recorded on how staff where to assist this person. For example, if they became confused.

The manager and staff had updated some people's "This is me" form while other people's were still waiting for updates to be completed. This meant staff had clearer guidance about how some people needed to be supported to help keep them safe.

Infection control audits were now completed and no further outbreaks of infectious illness had occurred since the last inspection. Most staff had now completed infection control training and gloves and aprons were available around the service. This meant staff had the knowledge and skills in place to maintain safe infection control practices.

14 people were living at the home and the rota and staff confirmed the service now had sufficient staff to meet people's needs. The provider had employed a new deputy manager to support the manager. There were plans to increase the day staff and waking night staff number as the number of people living in the service increased. We observed a calmer happier home with one staff saying, "Everything has improved including staffing numbers." The manager said staffing numbers would be increased when the number of people admitted increased.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 22, 29 and 31 March and 2 April 2016 we found a lack of quality monitoring of the service as systems and processes were not always in place to ensure good governance. Audits had not always been completed to identify concerns, such as those found during the inspection. Information about people's accidents and falls were not being effectively used to identify themes, to help keep people safe and prevent further incidents. An infection control audit had not been reviewed to ensure any further risk of infection was detected and controlled. At this inspection, we found the manager had taken action to address these shortfalls although further action was needed in relation to updating care records and the regular completion of audits and risk assessments.

The service had been without a registered manager since May 2015. The registered nominated individual was currently unavailable with no date of their future availability. The manager was in the process of registering with us and had made progress in the development of updating records and other systems. They were being supported by the Chairperson of the Board of Trustees and an external auditor to assist with their action plan.

At this inspection we discussed with the manager what improvements had been made to meet legal requirements in relation to good governance since the last inspection. The manager had a meeting with an external auditor, employed by the Patricia Venton House board of trustees, to assist with implementing the service action plan sent to us and updating all records. This included carrying out quality assurance audits on all records held.

The action plan sent to CQC said; "The warning notice issued to the service has stated the deadline for compliance to be 1 August 2016. All of the necessary actions will be taken to ensure the service is in compliance with regulations by this date. However continuous improvement and embedding a new culture may take more time and we would wish to assure the CQC of our commitment to the above improvements to the benefit of our service users."

Systems in respect of assessing the quality continued to not ensure people received a quality service. We found the manager had introduced a new approach for monitoring the systems and processes in place. The audits were to be carried out monthly and the new system had been in place less than two weeks. New auditing tools had been developed, including a medicines audit. However, it was too early to judge this had been effective and this had not yet been used on the new medicine system. The lack of audit meant the concerns found at this inspection had not been identified by the provider.

The systems in place to monitor the quality of service people received were not effective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's records continued to not have the details required by staff to deliver care that was appropriate. Gaps in some people's records made it difficult to follow the care. We found people's care records were in the process of being updated with some completed and others requiring work. For example, risk

assessments, medical profiles and daily care needs still needed further information to ensure they reflected people's current needs and risks. The service had employed an external auditor to assist them with the development of care records in light of concerns raised at the previous inspection. The auditor received updated care records from the manager. The auditor would make any recommended changes which the manager was in the progress of implementing.

An accurate, complete and contemporaneous record for each person was not maintained. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was talking to people, relatives and healthcare professionals to ensure all files had the correct information to meet people's needs. Pre-admission assessments systems were being rewritten for people who may come in for respite care and people who may want to move in to Patricia Venton House.

The infection control audit, already in place, was being overseen by the manager to ensure it was completed and any issues were acted upon.

The service action plans recorded in response to audits of falls and accidents; "Management Meetings will take place including our independent consultant in order to review progress, challenges, successes, progress, risks, incidents and accidents and ensure the appropriate steps are taken to mitigate any risk of harm and to ensure continual improvements are made within the service as per our internal action plan." One person had been referred to the falls clinic to assist this person and help staff keep them safe.

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 Regulation 12(1) and (2) (g) The registered person had not ensured the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) and (2) (a) (c) The registered person had not assessed, monitored and improved the quality and safety and welfare of service users. The registered person had not maintained an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided