Mr & Mrs T F Chon

Parkside Residential Home

Inspection report

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Ratings

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 12 July 2016 and found significant shortfalls in the care provided to people. We identified breaches of regulations relating to consent, risk management, staffing, person centred care, nutrition and hydration, complaints, notifications, record keeping and quality assurance. In addition, the provider was not providing care in a safe way as they were not doing all that was reasonably practicable to ensure the safe management of medicines. Following the inspection we served a warning notice on the provider requiring them to comply with the regulations for the safe management of medicines.

We undertook this unannounced focused inspection on 8 November 2016 to check that the provider had met the requirements of the warning notice. At this inspection we looked at aspects of the key question 'Is the service safe?' This report only covers our findings in relation to the focused inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Parkside Residential Home' on our website at www.cqc.org.uk.

Parkside Residential Home is a residential home for up to 30 adults with dementia and mental health needs.

The home had 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.

During our focused inspection we found the provider had made considerable improvements with medicines. Medicines were stored and managed safely. People were receiving their medicines on time and when they needed them. Staff had been recently trained and their competency had been assessed to ensure they handled medicines safely. Regular audits were being completed to ensure the management of medicines was safe and follow up action was recorded.

The home had met the requirements and regulations identified in the warning notice. We have changed the rating for this key question to 'Requires Improvement'. Although improvements had been made we need to see consistent improvements over time and there were other issues within this key question that we identified at the last comprehensive inspection that need to be addressed.

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 provider had made improvements to medicines storage, recording and administration so that people were receiving their medicines safely as prescribed.

We have changed the rating for this key question to 'Requires Improvement'. Although improvements had been made we need to see consistent improvements over time and there were other issues within this key question that we identified at the last comprehensive inspection that need to be addressed.

Parkside Residential 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 unannounced focused inspection was undertaken by a CQC pharmacist on 8 November 2016. This inspection was arranged to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 12 July 2016 had been made with medicines.

We inspected the service against one of the five questions we ask about services: Is the service safe?

Before our inspection we reviewed the information we held about the service. During our inspection we looked at records relating to the administration of medicines for 16 people. We also looked at records relating to staff training. We spoke with the provider and registered manager.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of the service on 12 July 2016, the provider had not ensured medicines were always managed properly and safely and people were being put at risk of harm. Specifically, we found that some medicines were not stored and disposed safely, people's Medicines Administration Records (MAR) were not always completed in full or accurately and medicines being signed for as administered was not given. Internal medicines audits had not been carried out and the external medicine audit carried out by a pharmacist in February 2016 that identified majority of the shortfalls we found had not been addressed. Senior staff and the manager did not have current medicine training and their competencies had not been tested annually. We also observed that medicine was not being administered in a safe way therefore putting people at risk of harm. Following the inspection we served a warning notice on the provider requiring them to comply with the regulations for the safe management of medicines.

During this inspection, the provider had met the requirements of the warning notice. We saw appropriate arrangements were in place for obtaining medicines. The provider and registered manager told us how medicines were obtained and we saw that supplies were available to enable people to have their medicines when they needed them.

As part of this inspection we looked at the medicine administration records for 16 people. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded. For those people who were unable to swallow tablets we saw the doctor had prescribed dispersible tablets or liquids.

Any medicines no longer required by the home were returned to the supplying pharmacy at the end of each monthly cycle. The fridge temperature was being monitored and recorded daily within the recommended temperature range.

We saw one person self-administered their medicine. This was managed appropriately with signed consents in place and a completed risk assessment.

We saw all care staff who administered medicines had undergone training in July 2016 and competency assessments had been completed by the registered manager.

Controlled drugs were stored and managed appropriately. One person was prescribed a controlled drug and there was an accurate record maintained.

We also saw the provider did weekly audits to ensure the administration of medicine was being recorded correctly. Records showed any concerns were highlighted and action taken. This meant the provider had systems in place to monitor the quality of medicines management.