Bupa Care Homes (CFHCare) Limited

Copper Hill Residential and Nursing Home

Inspection report

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Ratings

Is the service safe?	**Requires improvement**

Overall summary

This was an unannounced inspection carried out on the 5 August 2015.

Copper Hill Residential and Nursing Home is a large care home with nursing and is registered to provide accommodation for up to 180 people. It provides residential services, nursing care services and dementia care services across six separate units. At the time of our inspection there were 97 people living at the home in five of the units.

At the last comprehensive inspection in November 2014 we found the provider had breached two regulations associated with the Health and Social Care Act 2008.

We found that medication practice was not safe and improvements were needed. There was a risk that people would not receive their prescribed medications as directed. People were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. We also found at that inspection that people were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained. Individual risks had been assessed and identified as part of the care planning process. However, the documentation showing how risks were managed were not easily accessible to all staff.

We told the provider they needed to take action and we received a report in March 2015 setting out the action they would take to meet the regulations.

At this focused inspection on 5 August 2015 we found improvements had been made with regard to these breaches. However, we found improvements were still needed to ensure medication practice was consistently safe. This report only covers our findings in relation to these two previous breaches of regulation. You can read the report of our last comprehensive inspection, by selecting the 'all reports' link for Copper Hill Residential and Nursing Home on our web site at www.cqc.org.uk

Summary of findings

There was a registered manager in post. 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.

We found at this focused inspection that systems in place did not fully ensure that people who used the service received their medication as prescribed at all times.

Records we looked at showed that when people were prescribed topical medicine,(such as creams) the instructions for their use were not at times fully documented. Topical medicine protocol and administration records (TMPAR) were not consistently completed when topical medicines were administered; therefore it was unclear if these medicines were given as prescribed. Topical medicines were not stored as the provider's policy stated.

An assessment tool was used to monitor pain for people who used the service who could not speak. This was not carried out as the provider's policy instructed, which meant there was a risk people may not receive pain relief medication when needed. Records for pain relief patches showed that some people's patches were not being placed on the skin at different sites with the required interval of time in between (to avoid skin irritation) as described by the manufacturer's instructions.

Records showed that the actual times of medication administration were not documented. This meant that there was a risk that at times the required interval of time in between doses would not be adhered to.

Medication policies and staff's training on medicines was up to date. Overall, appropriate arrangements for the storage and disposal of medication were in place. Controlled drugs were safely managed. Regular stock checks were completed.

Staff understood how to keep people safe and knew the people they were supporting very well. Risk management plans had been developed from risk assessments and were centred on the individual needs of people who used the service.

We found the home was in breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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?

The service was still not consistently safe.

Medication practice was not always safe and improvements were needed. There was a risk that people would not receive their prescribed medications as directed.

There were policies and procedures in place to manage risk to people who used the service. Staff consistently followed risk management plans to ensure the safety of people who used the service.

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

Requires improvement

Copper Hill Residential and Nursing 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 checked 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 5 August 2015 and was unannounced.

At the time of our inspection there were 97 people living at the home. During our visit we spoke with seven people living at the home, 19 members of staff, one visiting health professional, the clinical services manager and the regional manager.

We spent some time observing care in the communal areas to help us understand the experience of people living at the home. We spent some time looking at documents and records that related to people's care and the management of the home. We looked at six people's care records and 50 people's medication records.

The inspection team consisted of three adult social care inspectors and two specialist advisors in nursing and dementia care.

Before our inspection, we reviewed all the information we held about the home including previous inspection reports. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Copper Hill Residential and Nursing Home on 19 and 27 November 2014 we found that people were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained. We saw individual risks had been assessed and identified as part of the care planning process. However, the documentation showing how risks were managed were not easily accessible to all staff.

This was a breach of Regulation 20 (Records); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (which corresponds to Regulation 17- Good governance of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014)

At our focused inspection on 5 August 2015 we found the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of regulation 20 described above.

We found that risk assessments and management plans were completed and centred on the individual needs of people who used the service. Strategies were in place to make sure risks were anticipated, identified and managed. They included a supporting care plan and tools that measured risks were completed and used to inform the care plans. The risk assessments we saw included falls, weight loss, epilepsy, communication, mental health and choking. These identified hazards that people might face and provided guidance about what action staff needed to take in order to reduce or eliminate the risk of harm. This helped ensure people were supported to take responsible risks as part of their daily lifestyle with the minimum necessary restrictions.

We saw for one person that had been identified as being at high risk of falls the management plan stated; 'Staff to ensure Crash Mat/Sensory Mat is in place and the bed is set at the lowest height'. Another person was at high risk from weight loss. We saw they had been weighed regularly and were maintaining a healthy weight. A person who was at high risk from falls had care plans in place to ensure they were supported to avoid falls. We saw that risk management plans were written in a person centred way. One person who used the service had been identified as having risks regarding their communication. The guidance in the management plan said; 'Staff to speak in a clear, soft voice and observe for body language and facial expressions. Staff to check regularly throughout the day when he is in his room. When he has any appointments, a member of staff will need to go with him. He should be encouraged to sit in the lounge to prevent isolation.' The daily records we looked at showed staff followed the guidance in this management plan and were monitoring the person when they were alone and asking them daily if they wanted to sit in the lounge.

The records we looked at were easy to navigate and access important information. At the front of the record there was an index which highlighted risks for people who used the service. Staff said the documentation had improved and was much easier to use. They said they found the index information really helpful as an overview and introduction to the person and their risk management needs. One staff member said, "The care plans are easy to use and updating them is always done as they are needed, we don't just use the review date." Another said, "The new documentation is so much better, more detailed, more understandable and you can find what you want without having to search and search like before."

All the risk assessments we looked at were up to date and all had a corresponding management plan to show how the risk was managed. Staff we spoke with were able to describe people's individual risk management plans and how they supported people to have the most freedom possible regardless of their disability or needs. Staff spoke about how they managed negative behaviours of people who used the service in a positive way to maximise independence and encourage self-esteem. People who used the service said they felt safe.

We also found at our last comprehensive inspection that medication practice was not safe and improvements were needed. There was a risk that people would not receive their prescribed medications as directed. People were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

This was a breach of Breach of Regulation 13 (Management of medicine); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (which corresponds to Regulation 12- Safe care and treatment of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014)

Requires improvement

Is the service safe?

At our focused inspection on 5 August 2015 we found the provider had followed the action plan they had written to meet some of the shortfalls in relation to the requirements of regulation 13 described above. However, further improvements were still needed.

We looked at the management of medicines. We found that the service had up-to-date policies and procedures in place, which were regularly reviewed, to support staff and to ensure that medicines were managed in accordance with current regulations and guidance. The area manager told us that relevant staff had undertaken medicines training to ensure that staff managed medicines in a safe way and made sure people who used the service received their medicines as prescribed. Records we looked at showed that training on medicines was 100% up to date. The area manager said staff's competency was assessed on an annual basis and we saw there was a training matrix in place to make sure this was completed when due. Staff we spoke with confirmed they had received training and annual competency checks.

Most medicines were securely stored in a locked trolley, in a locked room with the key held by the person in charge of the shift. We saw that some steroid creams were not securely stored and that one bottle of eye drops which should have been discarded after 28 days of opening were still in use 33 days after opening which may have meant it was ineffective. The home's policy stated that topical creams should be stored in a locked cabinet or drawer if stored in people's rooms. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines that require extra checks and special storage arrangements because of their potential for misuse. The controlled drugs book was in good order and medicines were clearly recorded. There was evidence of regular stock checks and recorded stock balances were correct.

Medicines requiring cool storage were kept in a fridge which was within a locked room. We saw that temperatures relating to refrigeration had been recorded daily and were overall between 2 and 8 degrees centigrade. We saw that temperatures for the treatment rooms were recorded daily and they were less than 25 degrees centigrade to ensure medicines were stored as per manufacturer's instructions. However, on one unit we saw the fridge temperature had been recorded as above 8 degrees centigrade on three occasions and it appeared no action had been taken. The nurse on duty said they would take urgent and immediate action to rectify this.

A nurse on one unit told us the morning medicine round usually took up to two and a half hours. The time of administration on the MAR was 'breakfast'. Some people received their medicines when they got up in the morning and some people preferred to get up later than others. However, the actual time of administration of regular medicines was not recorded. The subsequent medicine round was recorded as 'lunch' and the nurse said this meant between one o'clock and one thirty. One person was prescribed an antibiotic three times a day to be given at 10am, 2pm and 9pm. We saw that this was given at 10.45am on the day of inspection and the nurse said the next dose would be at about one o'clock with the last dose at about nine pm. This would not be as prescribed. We brought this to the attention of the nurse. On another unit, we asked how the nurse ensured that the times between rounds was within safe limits of medication administration. They said, "We always start with the same residents so that the time from the last round is the longest." Because actual time of administration was not recorded, it was not possible to determine if all medicines were given as prescribed.

We observed medication administration in some units. The nurse understood how each person preferred to take their medicines. For example we saw that one person preferred to take their medicines from a spoon while others transferred them from a medicine pot to their mouth themselves. The MAR was signed only after medicines had been administered. We saw on another unit that the staff member who administered the medication spoke with dignity and respect to the people who used the service and displayed individual knowledge of their preferences. A current photograph of each person was attached to their MARs to ensure there were no mistakes of identity when administering medicines.

The covert administration of medicines occurs when a medicine is administered in a disguised format without the knowledge or the consent of the person. We saw that some people had covert medication administration plans in place and this documentation had improved since our last visit to the service. The documentation showed a box was ticked to say a pharmacist had been involved. However, the

pharmacists were unnamed and no pharmacist instructions for how each medicine could be given covertly were included in the care plan. The clinical services manager told us this information was in a letter on each person's file and included in medication review information. We saw for some people that a covering letter from their GP agreeing to covert administration was in place. We saw for some people that the method of covert administration for each medicine had not always been recorded or differed from what the nurse told us. For example for two people the nurse said, "If they won't take it I put it in food." A care plan said they took their medication better if taken in drinks such as tea or juice which meant staff may not follow the care plan instructions.

We looked at MAR charts and saw these were completed to show entries had been initialled by staff to show that medications had been administered. However, when we looked at Topical Medicine Protocol and Administration Records (TMPAR) we could not be sure that creams and lotions had been used as prescribed; actual use was not recorded and therefore effectiveness was not measured.

Most of the records we looked at did not include detailed instructions for the use of creams to allow care staff to know when and where to apply the creams. For example, instructions were noted as 'apply as needed' or 'as prescribed.' We discussed the application of creams with staff. Answers differed as to how often creams were to be used and what they were used for. One staff member said, "We don't sign it every time we put cream on, maybe once a day." All of the staff we spoke with said that when people had barrier creams prescribed they applied it every time they delivered personal care which was at least four times a day. Records showed signatures only once each day on most of the TMPAR's we looked at, or in some cases not at all. This means there was a risk that creams and lotions may not be used as prescribed.

The area manager said topical medicines were covered as part of the medicines training they had in place for the service. They said that in light of the shortfalls we had found regarding topical medicines they would be speaking to the training department and arranging some bespoke training on topical medicines. After the inspection, the registered manager contacted us to say this had commenced.

We saw that some people had been prescribed controlled drugs in the form of a transdermal patch for pain relief. Staff we spoke with knew why these people experienced pain and needed the medicine. The administration records included charts with a body map to show where the patch was placed. For some people we saw the records were fully completed confirming the patch was intact and that rotation of the application of patch was appropriately taking place. However, records for some people showed these were not always being placed on the skin at different sites with the required interval of time in between as described by the manufacturer's instructions and noted in the policy of the service. This could lead to skin damage. We also saw contradictory information on the body map for one person which showed an 'x' indicating the patch had been applied to the left side of their back, but the note next to the image stated 'right back'.

During the course of our inspection, the clinical services manager designed and introduced to staff on each unit, new documentation to record patch administration. They said the design of the document would make the rotation and frequency of rotation clearer to see.

Some people were prescribed medications with specific instructions for their use or to be used as and when necessary (PRN). We saw there were clear protocols in place which included the maximum usage. Other medications such as those requiring early administration in the morning were documented on MAR charts and signed as given at the time needed. We were told additional information on why medications had specific instructions were available in each unit in the 'patient information leaflets' supplied by the pharmacist.

People who had been identified as having a risk of pain had a pain monitoring chart in their records. The chart included non-verbal cues which helped staff identify pain for people who could not speak. The policy of the service was that this should be recorded twice a day. We saw for some people this was done and their pain was monitored and responded to in this way. However, we observed that one person who used the service cried out when being re-positioned by staff. The pain assessment chart for this person had been completed eight times in the previous six days and all entries where '0' which meant pain free. We received conflicting information regarding this person's pain management and pain relief. One staff member said, "He always screams out when we move him." Another said, "He used to be on [name of pain relief medication] I don't know why they stopped it because he wasn't in any pain

Requires improvement

Is the service safe?

then." The clinical services manager told us that staff had reported the person was distressed by our presence on the unit and was not in pain. They said they would now refer this person to the pain management team for review. After our inspection we were provided with information which gave details of the person's current pain and behaviour management and information on when and why pain relief medication had been used or ceased to be used. This information was from the person's hospital consultant.

We were shown a number of medication audits which were undertaken on an on-going basis, including the MAR charts, to check that medicines were being administered safely and appropriately. These included a weekly check completed by unit managers, submitted to the clinical services manager who then carried out an additional random weekly check. We looked at records for all units and saw that occasionally actions were identified such as gaps in MAR charts or the need for medication protocols to be updated.

We saw there was then a monthly audit of medication on each unit, carried out by the clinical services manager. These were scored and RAG (red, amber, green) rated depending on compliance with policy and practice. Issues identified were similar to the concerns we had found on our visit. They included; covert medication plans that needed to be updated, patch medication administration not recorded fully and topical medicines that needed a protocol for use. We saw for the last six months most units were rated green with a high level of compliance. Two units were rated amber; one for one month only and one had been so for the last five months. The area manager told us this was addressed and checked through provider monitoring visits. However, the records we looked at did not clearly show how this had been addressed. There was no individual action plan for this unit. The area manager agreed to make sure this was rectified with more detailed recordings in the future to ensure audits were sufficiently robust. Meeting minutes from meetings with unit managers showed that medication was a standing item on the agenda and improvements needed were discussed and followed up on.

We concluded that although there had been improvements to medicines management overall, there was still a risk that people would not receive all their medicines as prescribed. This was a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not always protected against the risks associated with medicines because the provider did not always have appropriate arrangements in place to manage medicines.