Four Seasons (Bamford) Limited

Churchfield Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 17 and 18 February 2015. Breaches of legal requirements were found. We took action against the provider in relation to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We also found other breaches of regulations but we did not follow these up at this focused inspection.

We undertook this focused inspection on 27 April 2015 to check that the provider had made improvements to ensure people received their medicines safely and to confirm that they now met the legal requirement. This report only covers our findings in relation to that requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Churchfield Care Centre on our website at www.cqc.org.uk.

The provider had a registered manager in place at the time of our inspection. 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 2008 and associated Regulations about how the service is run.

Improvements had been made in relation to how medicines were managed and administered to people and regular audits were being carried out to ensure this was sustained. People were now receiving their medicines as prescribed by their doctor. More improvements were needed in relation to the management of medicines in relation to following manufacturer's guidance and giving staff information about how some medicines were to be administered. This was particularly important for medicines given covertly, which meant the people concerned did not

Summary of findings

know they were taking them. The registered manager had already commenced clarifying information about this. Further improvements were also needed to ensure all medicines were always stored at safe temperatures.

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 not consistently safe.

Action had been taken to improve the safety of medicines and people received their medicines as prescribed. In order to ensure all medicines were given safely, further improvements were needed in relation to following manufacturer's guidance, giving staff more information about how some medicines were to be administered and ensuring all medicines were always stored at safe temperatures.

Requires improvement

Churchfield Care Centre

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Churchfield Care Centre on 27 April 2015. We visited to check that improvements had been made to meet legal requirements following our inspection on 17 and 18 February 2015.

We inspected the service against one of the five questions we ask about services: is the service safe? We only inspected the safety of medicines. This is because we had taken enforcement action by issuing a warning notice with respect to the legal requirement about the management of medicines. We will follow up and report on other improvements at a later date.

The inspection was undertaken by two inspectors, one of whom was a pharmacist inspector. During our inspection we spoke with two people who used the service, two staff and the manager. We looked at the medicine records of 16 people who used the service.

Requires improvement

Is the service safe?

Our findings

When we inspected the service on 17 and 18 February 2015 we had concerns that people were not receiving their medicines as prescribed by their doctor. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We took action against the provider by serving a warning notice and told them they must make improvements by 16 March 2015.

At this inspection we looked at the management of medicines and overall we found that sufficient improvements had been made to address the serious concerns we had raised following our previous inspection. However, we discussed with the acting manager that although improvements had been made we identified further specific medicine management issues that still required some improvement.

Both people we spoke with told us they were receiving their medicines when they should. We observed the nurse on duty giving people their medicines and saw that they carried out the task safely and were kind in the way they spoke with people. They explained what each medicine was for and spent time with each person ensuring the medicines were taken correctly and safely.

Previously, we found a nurse was tired from working excessive hours and had difficulty concentrating on giving medicines. The nurse on duty when we visited on this occasion had commenced her shift that morning and had no problems with concentration. The nurse described how they prioritised people who needed their medicines four times each day, so that they were given first in the morning. This ensured an adequate time interval between doses. Some people who chose not to get up and have their breakfast early had their medicines a little later and this was appropriate for the medicines they were prescribed. The nurse also said that they knew clearly which people were diabetic and dependent on insulin. They did blood glucose tests and administered insulin at mealtimes in line with their care plan. One person confirmed they had received their insulin at the right time and we saw clear records that the procedure had been completed. We saw there were reminders for this on white boards in the nurse's office. This meant that medicnes were given more safely than at our previous inspection.

We also saw 'Snap shot files' that contained brief, but useful information about each person to assist all staff, but particularly temporary nurses and new staff to identify medical needs quickly. The manager told us there was still a need to use agency nurses for some shifts, but they always requested nurses that were familiar with the service. Also, if any nurse could not identify people, a member of the care staff was allocated to work together with them. This meant that the nurse could administer all medicines more quickly than previously.

In both units, we looked at a sample of people's medicine administration records (MARs). We found they were appropriately initialled to show medicines was given or a code was used to explain why a medicine had not been given. An explanation was sometimes included on the reverse of the record sheets, but not always. There were secure arrangements for destroying any unused medicines.

We had previous concerns about handwritten prescription entries on the MARs that had not been checked and signed by a second person as correct. On this visit we found all handwritten prescription entries were appropriately witnessed and signed as correct. This gave more assurance that instructions for these medicines were correctly written down and, overall, the records in both units showed that people had been given their medicines as prescribed.

However, whilst reviewing the MARs we saw that some people received their medicines through the use of a skin patch. There were body map drawings to indicate where each patch had been applied, but the manufacturer's guidance was to not use the same site again for a three week period and this was not followed according to the completed body map records. This means that people's skin areas may be become irritated and affect the way the medicine is absorbed.

We also noted that information regarding people's allergies to some medicines was written on the MARs in order to prevent future risks, but for one person this differed from that on 'Snap shot files' and checks need to be made to ensure all information is correct to keep people safe.

We found, in both units, there were some people who received their medicines covertly, which meant the people concerned did not know they were taking them. Care staff in the Pine Trees unit told us this was done for one person only if they refused the medicine they needed. They knew how to hide the tablet in a small amount of cold food and

Requires improvement

Is the service safe?

this was done safely. However, the guidance for this was not written down for other staff to follow. We found this was similar in the nursing unit. We saw mental capacity assessments had been carried out and a GP had agreed that medicines could generally be given covertly for some people, but there was no clear guidance in care plans or with the medicine records about how people were to be given medicines covertly. We discussed this with the manager who told us they were taking advice from a pharmacist and would then clarify directions for staff to follow.

Medicines were stored within a clinic room in each unit and the temperature of the rooms was monitored for safe medicine storage. We also saw the daily temperature records for the medicine refrigerators and in the nursing unit, we saw that temperatures outside the safe storage range had been recorded. We discussed this with the manager, who was not aware of any action taken about this. She immediately arranged for further checks to be made and for a new thermometer to be used. We were, though, concerned that staff did not know of action they needed to take when finding temperatures were outside the safe range.

We discussed all our findings with the registered manager who told us they would make the improvements needed to address our additional concerns.