Embrace All Limited

Sydmar Lodge

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 4 June 2015. Breaches of legal requirements were found. This was because we found that people in the service may not have been receiving their medicines as prescribed. We also found that complaints processes were not responsive to people's needs, and that the provider's auditing processes were not fully effective at identifying some risks to people's health, safety and welfare.

We served enforcement warning notices against the provider for two of the breaches because they were similar to concerns we found at our November 2014 inspection. We rated the service as 'Requires Improvement'. After the June 2015 inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We carried out this unannounced focused inspection on 24 August 2015 to check that the provider had followed their plan and to confirm that they now met legal requirements. The report only covers our findings in relation to these matters. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Sydmar Lodge on our website at www.cqc.org.uk .

Sydmar Lodge provides accommodation for up to 57 people who require support with their personal care. The service provides support for older people and people living with dementia. At this inspection, the registered manager informed us there were 44 people using the service and there was a maximum practical occupancy of 49 so that people were not sharing rooms. The premises is a purpose-built care home with passenger lift access to the first and second floor.

The registered manager was present throughout the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

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.

At this inspection, people and their relatives told us about the caring nature of staff and the responsiveness of the service. We saw staff attending to people in a pleasant manner, and there was a warm and engaging atmosphere in the service.

We found that complaints processes were now responsive to people's needs. People's concerns were being addressed informally. Complaints processes were more accessible and advised complainants what they could do if they were unhappy with investigations. The provider took action to resolve people's complaints.

The provider had made some of the necessary improvements with medicines. However, we still found some concerns with how medicines were managed safely, which put people at ongoing risk of unsafe care and treatment. In particular, one person had not received a pain-relief controlled drug for 21 days that was prescribed for administration at least every four days. A few other people may not have consistently received their medicines as prescribed, including eye-drops for glaucoma for one person. There were ineffective daily checks to ensure that medicines had been administered as prescribed, and had been recorded.

As a result of the above, we found that the provider's auditing and governance processes were still not fully effective at identifying some risks to people's health, safety and welfare.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking enforcement action against the provider for the continuing breach in respect of safe and proper medicines management, and will report on that fully when completed. Details of these breaches are 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?

Inadequate

The service was not safe. We found a number of ways in which management of medicines was still not safe. This included a tablet being left unattended, medicines being administered to people late, inconsistent medicines records, and ineffective checks to ensure that medicines were administered as prescribed.

One person had not received a pain-relief controlled drug for 21 days that was prescribed for administration at least every four days. There were no records to demonstrate that another person had received a prescribed eye-drop medicine for glaucoma for eight days. There was a risk that two people had not received prescribed injections in a timely manner.

Is the service responsive?

Good

The service was responsive. Concerns and complaints were now being responded to. Complainants were advised of what they could do if they were unhappy with investigations into their complaint. Complaints processes were accessible. The provider took action to resolve people's complaints.

Is the service well-led?

Requires improvement

The service was not consistently well-led. There were systems of auditing quality and risk at the service. However, the provider's auditing and governance processes were still not fully effective at identifying some risks to people's health, safety and welfare. This was primarily because medicines audits had not identified the concerns we found in respect of the safe and proper management of medicines.

Sydmar Lodge

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 inspection took place on 24 August 2015 and was unannounced. The inspection team comprised of two inspectors, one of whom was a pharmacist inspector.

Before the inspection we looked at the information we held about the service including notifications they had sent us and information from the local authority.

During the visit, we spoke with eight people using the service, two visiting relatives, four staff members, the registered manager, and a member of the senior management team.

We checked medicines storage, medicines supplies, and medicines records for approximately 30 people using the service. We looked at care plans and care records for people in relation to medicines matters. We also looked at records relating to the management of the service, including complaints records, and observed people's care and support in communal areas.

Inadequate

Is the service safe?

Our findings

At our previous inspection of 4 June 2015, we found a number of discrepancies between medicines records and the remaining stock. Health professional advice for one person's as-required medicines had not been updated on the person's records and was not being kept under review in the service. This put people at risk of not receiving their medicines as prescribed. This meant the provider was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served an enforcement warning notice against the provider for this breach.

At this inspection, whilst we found that the provider had addressed some of the specific medicines concerns of our last inspection, there were still ways in which medicines were not being managed safely, putting people at ongoing risk of not receiving their medicines as prescribed.

We saw that the prescriber had reviewed the use of an antipsychotic medicine for one person's anxiety. There was an instruction to give this regularly at night, and at other times as needed. There was clear guidance on the circumstances under which staff should administer this medicine. We saw from the medicines administration record (MAR) that it had not been necessary to administer this medicine during the day, as staff had identified triggers for this person's anxiety, and had made some changes to the person's care to reduce the risk of them becoming anxious.

We checked 24 people's MAR against stocks of separately-boxed medicines. In 23 cases, there were no discrepancies. The service had put in place stock balance-check sheets after our last inspection, to identify stock discrepancies in a timely manner. This had helped to resolve the issues with medicines discrepancies. However, for one person, two more paracetamol 500mg tablets were in stock compared to what had been recorded as given. This was a medicine prescribed for use when required (PRN). Stock balance-check sheets were not being used for blister-packed PRN medicines, so the above discrepancy had not been identified. This put the person at risk of receiving unsafe care and treatment.

We noted that the arrangements for ordering repeat prescriptions had improved, as most people were now using the same pharmacist and the number of involved GPs had reduced. The monthly medicines cycle start date had been synchronised for most people, which helped reduce the risk of medicines errors.

When topical medicines were applied, and food supplements given, this was recorded on the MAR. The temperature of the medicines storage area and medicines fridge was monitored daily, and we saw from the monitoring records that these medicines were kept at the correct temperatures to remain effective.

The current MAR for one person included a pharmacist-generated record of a pain-relief patch that commenced on 20 August 2015 with instruction to apply every three days. However, the first four entries on the MAR, from 20 August 2015, were 'X' meaning not to administer. Subsequent entries across the 28 day period prompted for administration every four days. We established from discussion with staff and the pharmacist that on 22 August 2015 the service had received instruction from the prescriber to alter the application frequency to every four days; however, this instruction was not clearly documented on the MAR. When we asked staff for any other record to demonstrate the change of prescriber's instruction, none was supplied.

This person's current MAR also included a hand-written entry for the pain-relief patch, for administration every three days. There was no administration record for the patch since 4 August 2015. A quantity of seven patches was recorded on the MAR as received by the service but without a date of receipt. The controlled drugs record for this medicine stated that one patch was received on 20 August 2015, and a further seven were received on 21 August 2015. It contained no record of administering the patch. A senior staff member subsequently confirmed that the person had not had the patch administered.

The person's care file contained a GP medicines list for dated 28 July 2015 showing that the patch was prescribed for use every third day. However, the person's pain management support plan dated 11 August 2015 did not make reference to the patch, stating that the person was to have paracetamol as needed.

We spoke with the person receiving this medicine. They told us, "My knee is killing me." They could not confirm whether or not they had received the pain-relief patch

Is the service safe?

recently. A staff member told us the person had been receiving regular paracetamol, however, the person was in pain despite that. The person's MAR showed they received paracetamol four times daily since 4 August 2015.

Our evidence demonstrates that the person did not receive their prescribed pain-relief patch at all for a period of 21 days until we highlighted the concern at our inspection visit. This was not proper and safe management of the person's medicines, which failed to provide them with safe care and treatment.

The MAR for one person's glaucoma eye drops had not been signed for the current month, from 17 August 2015 onwards. The drops were available in a medicines trolley, and had a date of opening of 17 August 2015. Staff said they were not sure if this had been administered. They told us that the person sometimes refused to have these eye drops administered; however, the registered manager said she was not aware of this. Staff also said that they had been told at a recent staff handover meeting that the eye drops needed to be signed for when given. The person's current MAR showed that they were prescribed another eye drop medicine, and had been receiving these as prescribed. There was no note on the MAR or in the person's daily notes or care plan to say they had been refusing any eye drops. This placed this person at risk of not receiving adequate treatment for their glaucoma, which may have placed their eyesight at risk. This was not safe management of the person's medicines in support of their safe care and treatment.

Two people were prescribed injections, to be given every three months. There was no record on their current MAR to indicate that these had been given, or when the injections were due. One of the injections had been received into the service on 30 July 2015. We asked staff and the registered manager to let us know when these were due, but they did not give us this information during our visit. The registered manager told us that they had noticed this matter during an audit the previous week, but had not been able to find out when the injections were due. They told us that administering these injections was the responsibility of the community nursing team. However, by failing to record the date the injections were due on the MAR, these people may not have received the injections on time, which put them at risk of receiving unsafe care and treatment.

The MAR for one person had no record against a daily prescribed anti-histamine medicine on 17 August 2015. We found the medicine still in the corresponding blister pack for them on that day. The antihistamine tablet for another person was still in the blister pack for 23 August 2015, despite staff recording that they had administered this tablet. A third person had two sets of paracetamol tablets remaining in their 08:00 blister-pack. Whilst one was recorded on the MAR as refused, the other was recorded as administered on the corresponding date of 22 August 2015. Their MAR also had no record against a daily prescribed medicine on 23 August 2015 but the tablet was not in the blister pack, indicating it was given to the person despite the lack of confirming record. Daily audits of people's medicines, to ensure they had been given as prescribed, had not identified these errors. This was not proper management of medicines, which failed to provide care and treatment to people safely.

We noted that the morning medicines round on one of the floors was not completed by 11:15, and the round on another floor was ongoing at 10:45. These were for medicines prescribed to be administered at 08:00. This meant that some people received their medicines later than prescribed. As staff did not indicate on the MAR which medicines had been given later than the prescribed time, but signed the MAR as if medicines had been given at 08:00, we did not know which medicines had been given late. Some people were prescribed medicines for pain relief, and time critical medicines for Parkinson's disease. The afternoon medicines round began at 14:00, which meant that a sufficient gap may not been left between morning and afternoon doses of people's medicines, which put these people at risk of receiving unsafe care and treatment.

At 11:45 we saw a yellow tablet in an administration cup left on the medicines trolley outside the dining room. There were no staff in attendance. There was a risk that someone using the service could have taken this tablet in error. We drew this to the attention of a senior staff member, who told us that it was for a specific person using the service. They went off to administer the medicine. This was not safe and proper management of medicines, which put people at risk of unsafe care and treatment.

Some people were prescribed medicines to be administered as a variable dose, for example, one or two tablets for each dose. Staff had signed for administering these medicines every day on the current MAR, a period of

at least seven days, but for four people had not recorded the actual dose given. This was not proper management of medicines, which put people at risk of unsafe care and treatment.

We found extra supplies of two medicines in a medicines trolley for one person. Staff had not recorded receipt of these supplies on the person's MAR chart or anywhere else. A senior staff member confirmed that a record should have been made. This was not proper management of medicines.

The allergy status recorded on the MAR for two people was inconsistent. One person had four MAR charts for the current month. On three of the charts, the handwritten allergy status stated "none known", however, the pharmacist-generated fourth chart stated "anticoagulants." The 'personal profile' record in the person's care file confirmed that they were allergic to anticoagulants. They were not prescribed any anticoagulants. A second person's care records stated they were allergic to aspirin and flucloxacillin. However their current MAR stated they were allergic only to aspirin. They had not been prescribed any flucloxacillin. These allergy status inconsistencies were not proper management of medicines, which put people at risk of receiving unsafe care and treatment.

Two people were prescribed as-needed medicines, to be given at night. For one person this was a sleeping tablet, for the other, a sedating antihistamine. Both of these people were receiving these every night. The reason for administering a dose every night was not recorded anywhere. This was not proper management of medicines, which put these people at risk of receiving unsafe care and treatment as these medicines were not prescribed to be given every night.

The above evidence demonstrates an ongoing breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found one full and one partly-full sharps bins which did not have a date of first use, and therefore we did not know long these had been in use, which was a potential infection control issue.

Good

Is the service responsive?

Our findings

At our previous inspection of 4 June 2015, we found that complaints processes were not fully accessible. Whilst concerns and complaints were responded to, complainants were not advised of what they could do if they were unhappy with the provider's investigations into their complaint. There was also little analysis of complaint outcomes so as to ensure improvements. This meant the provider was in breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served an enforcement warning notice against the provider for this breach.

At this inspection, we found that the provider had addressed the breach of regulation. The complaints process was now accessible to people. The complaints procedure continued to be on display in the entrance hall. The registered manager told us that a copy of the service's Service User guide had been sent to people's representatives since our last inspection, having previously been distributed to everyone using the service. The guide included complaints processes. We saw records confirming that the guide had been sent. A relative of someone using the service confirmed that they had recently received this.

The provider's website now gave information on how to make complaints. This included a specific link on their page for Sydmar Lodge which lead to a summarised complaints procedure for the service. The procedure included contact details of the registered manager and senior managers, along with how to contact the Commission at any stage. This helped raise awareness to complainants on who to contact if they were not satisfied with the outcome of their complaint.

The registered manager told us that the service's allocated Rabbi was available to assist anyone who wanted support to make a complaint. Leaflets for the Relatives and Residents Association were available at the service's entrance desk as another source of support.

The registered manager showed us that the provider's template response letters to complainants had been adjusted across the organisation to include how to raise concerns with the Commission if unsatisfied with complaint investigation outcomes. Complainants were also sent a copy of the complaint procedure, which contained details of how to inform the provider if they were dissatisfied with complaint investigation outcomes. We saw that these processes had occurred for the most recent complaint received. The response was also explanatory and conciliatory. The registered manager told us they planned now to meet the complainant to further resolve matters.

The service's complaint file was now well organised and arranged in date order. There was a summary of each complaint which showed what the key issue was, how quickly matters had been addressed, and the extent to which the complainant was satisfied with the outcome.

There were two other complaints recorded in the complaints file since our last inspection. One was by someone using the service about an aspect of their room. Records indicated that the first solution had not resolved the complaint. However, when we spoke with the person, they confirmed that the matter had now been satisfactorily addressed. A plan was put in place for the other complaint. We checked with involved staff and found they were aware of the plan. They demonstrated what they had done to follow the plan. This all helped to assure us that actions were taken to address people's complaints.

The registered manager told us there had been no formal audit of complaints since our last inspection because of the recent low levels of complaints. However, she had good knowledge of recent complaints and responses, and she told us that systems were in place to audit when needed. Additionally, all significant complaints were passed onto the provider's management board for oversight and scrutiny.

We checked minutes of the recent meetings for people using the service. A separate meeting was held for people's representatives. This Friends and Family meeting was most recently chaired by a relative of someone using the service, which was evidence of a positive and inclusive culture at the service. Both meetings showed evidence of both positive and negative comments about the service being raised, and plans being set to address service shortfalls. We saw that representatives were also advised to record maintenance and domestic issues in books on the front desk, and to raise any issues directly with the registered manager.

Most people using the service told us it was responsive. Their comments included, "It's fantastic here" and "I can't

Good

Is the service responsive?

find any fault." One person told us of the registered manager resolving a safety concern they had. A relative added that the registered manager was always available, and took action to address any concerns.

Requires improvement

Is the service well-led?

Our findings

The registered manager told us that all staff administering medicines had undergone competency assessments. The registered manager, the supplying pharmacist and the CCG pharmacist had carried out recent medicines audits. We saw that some of the issues identified had been addressed. Staff carried out daily MAR chart audits. However, these audits had not identified the risks to the safe and proper management of medicines that we found.

Medicines records were not always filed away correctly. We found a pile, approximately 30cm high, of completed MAR dated from February 2015 onwards on a counter top in the medicines room. There was loose medicines paperwork in various other places in that room, including paperwork that had fallen behind a cupboard. Our request to see older MAR for two people in relation to when they last had prescribed injections, could not therefore be addressed. The registered manager told us that there were plans to have these filed away.

There were systems of auditing quality and risk at the service, and action was taken to address shortfalls that these processes identified. However, we found some ongoing risks to people's health, safety and welfare that the auditing processes had not identified, in respect of the safe and proper management of medicines. Our findings demonstrate ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking further enforcement action against the provider in respect of this breach. This shows that the provider's quality auditing process was not fully effective at assessing, monitoring and mitigating the risks relating to people's health, safety and welfare.

The above evidence demonstrates a breach of Regulation 17(1)(2)(b) 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	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person failed to effectively operate systems and processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. [Regulation 17(1)(2)(b)]

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person failed to safely provide care and treatment to service users. This included a failure to properly and safely manage medicines. [Regulation 12(1)(2)(g)]

The enforcement action we took:
We served a Warning Notice on the Registered Provider, to become compliant with the regulation by 15 July 2015.