Bupa Care Homes (ANS) Limited

Stamford Care Home

Inspection report

21 Watermill Lane
Upper Edmonton
London
N18 1SH

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04 April 2017

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24 May 2017

Ratings

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

Summary of findings

Overall summary

At our previous inspection of this service on 1, 2 and 3 February 2017, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation relates to the safe management of medicines. Due to the seriousness of the concerns found we issued a warning notice to the provider and registered manager on 14 February 2017, requiring compliance with the Regulation by 1 March 2017.

This inspection took place on 4 April 2017 and was unannounced. This inspection was carried out by a single pharmacist inspector. This report only covers our findings in relation to the safe management of medicines within the safe section. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Stamford Care Home on our website at www.cqc.org.uk

A registered manager was in place. 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.

At this inspection we found that significant improvements had been made to how the service ensured safe medicines management. We found that medicines stocks balanced with what medicines administration records (MAR's) stated and medicines were stored safely and securely. We saw that the administration of medicines was documented appropriately.

However, the management of people's medicines administered via Percutaneous Endoscopic Gastrostomy (PEG) was not always in line with best practice guidelines and advice. The maximum fridge temperature used for storage of medicines was not documented; therefore we could not be assured that medicines inside the fridge were stored safely. Some staff who administer medicines had not their medicines training competency assessed.

Although the provider was no longer in breach of the medicines regulation, Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 we found that that improvement was required in aspects of medicines management.

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 service was not always safe. The provider had made significant improvements to how they managed medicines safely to address the breach of Regulation identified. However, we found that there were aspects of medicines management which required further remediation.

Stamford Care 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 focused inspection took place on 4 April 2017 and was unannounced. We inspected the service against one of the five questions we ask about services: is the service safe. This is because the service was not meeting some requirements. The inspection was carried out by a single pharmacist inspector.

This inspection was done to check that the provider was compliant with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as set out in the warning notice dated 14 February 2017 following our last comprehensive inspection on 1, 2 and 3 February 2017.

During the inspection we looked in detail at records relating to the safe management of medicines at the home. We looked at 20 records relating to medicines administration, care plans, medicines audits, training records in relation to medicines management and how medicines were stored. We spoke with the registered manager, deputy manager, area director and seven registered nurses. We observed two medicines rounds.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of the service on 1, 2 and 3 February 2017, we found that the provider was in breach of the regulation relating to medicines management. We found that some medicines were not stored and disposed safely. People's Medicine Administration Records (MAR's) were not always completed in full or accurately. Medicines were not always administered as prescribed. We issued a warning notice to the provider and registered manager on 14 February 2017, requiring compliance with the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 1 March 2017.

At this inspection we found that the provider had made significant improvements to address the concerns identified with medicines at our last inspection. However, we found that some aspects of medicines management were not always safe.

Medicines received from the pharmacy were recorded on the MAR charts and the quantity could be reconciled with the administration records which were clear and accurately documented. We checked the medicines disposal records and found these clearly detailed medicines that were returned or destroyed.

Medicines were stored safely and securely including controlled drugs, (CD's), these are medicines which are more liable to be misused and therefore needs close monitoring. Registers were in place to record the handling of CD's and we saw evidence of regular balance checks and appropriate documentation of destroyed CD's in the register.

We saw evidence that people who had their medicines administered covertly had appropriate documentation. This is when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them. An appropriate assessment must be performed by a medical practitioner to establish whether the person lacks mental capacity. If it is determined that the person does lack mental capacity to consent, a multidisciplinary discussion should follow to establish whether covert administration is in the service user's best interest. Paperwork was in place to document the process by which the covert medicines decision had been made with review dates.

Some medicines taken as needed or as required are known as 'PRN' medicines. Some people were prescribed PRN medicines for pain relief. Staff told us that PRN medicines were offered to people on a regular basis and that most people were able to communicate with them if in pain. We saw documented evidence that staff carried out regular pain assessments and there was pain assessment tool for staff to follow when administering these medicines.

We saw the use of patch charts for people who needed a pain relief patch. This meant it was clear to staff where and when patches had been applied, and reduced the risk of harm from duplicate application. Body maps and topical MAR were also in use in the service and these detailed where creams should be applied. This was especially useful as the topical creams were applied by carers in what appeared to be a delegated action, and signed for by nurses on people's MAR with a code C. The carers recorded these topical administrations in a separate administration tool which were checked by registered nurses.

Staff told us that the GP visits weekly and reviews people medicines regularly. We saw some evidence of medicines reviews carried out by people's GPs.

Fridge and room temperatures were monitored although maximum temperature was not recorded. We checked the maximum temperature of one of the fridge's and noted this to be 14°C, therefore we could not be assured that the temperature fluctuation for the fridges were within the recommended range which is between two and eight degrees Celsius. Therefore we could not be assured that medicines inside the fridge were stored safely.

Five people had Percutaneous Endoscopic Gastrostomy (PEG's) in situ and required medication via their PEG's. We reviewed both their MAR's and care plans, and noted that best practice guidance and recommendations were not consistently followed. For example, we saw on a MAR that one person had their anti-epileptic medicine administered at breakfast despite the recommendation by a healthcare profession to administer this in the evening to prevent interaction with the feeds. We also observed during one medicines round that staff did not wash their hands between two patients after administering medicines via PEG's. This could put people at risk of infections due to cross contamination.

Records showed that not all staff responsible for administering medicines had completed their competency assessment training, which senior staff at the service confirmed as correct. This had potential to undermine the safe management of people's medicines. Following the inspection, we requested additional information from the registered manager regarding the training and competency status of staff administering medicines which confirmed that all staff administering medicines had completed training with four staff requiring their competency to be assessed and signed off.