Abbeville RCH Limited

Abbeville Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 3 April 2017. On 31 July 2017 we were informed by the service about concerns relating to the safety of medicines administration in the home. We had also received concerns from another source about other risks to people's welfare.

As a result we undertook an unannounced focused inspection on 1 August 2017 to look into these concerns. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Abbeville Residential Care Home on our website at www.cqc.org.uk.

Abbeville Residential Care Home provides accommodation and care for up to 38 older people, some of whom may be living with dementia. At the time of this inspection on 1 August 2017 there were 19 people living in the home.

There was a manager in post however they had not registered with the Care Quality Commission (CQC). They told us that they were considering applying for registration. A registered manager is a person who has registered with the 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.

We had been advised by the service about a series of medicines errors during July 2017 that had resulted in some staff members being suspended from administering medicines to people.

Some of these errors had the potential to result in serious consequences for people's wellbeing.. A member of the CQC's medicine team checked the arrangements in place and found further potential medicines errors that had not been identified by the service. This suggested the medicines auditing arrangements in place were not robust. We asked the service to investigate these further errors.

This August 2017 inspection also identified a range of issues relating to cleanliness and infection control in the service. The provider's auditing arrangements had not identified these concerns.

Consequently, the provider was now in breach of Regulation 12 and Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. These relate to the safety and governance arrangements of the service respectively.

This service has experienced considerable difficulties in recent years but had made significant progress at the time of our April 2017 inspection. We are concerned at these recent developments. The provider is supplying regular updates to CQC in relation to the service provided to people and has been open about the current situation. However, we remain concerned about their ability to make and sustain improvements.

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.

The provider had reported a high level of medicines errors for the month of July 2017. This inspection identified further potential medicines errors for this month. People could not be sure of receiving their medicines as prescribed.

Areas of home including people's bedrooms and bathrooms were not clean which put people at risk of the spread of infection.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Auditing arrangements relating to medicines management and infection control were not robust.

Abbeville Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection in relation to concerns reported to us by the service about the safety of the administration of people's medicines. We had also been informed of concerns relating to other risks to people's welfare.

This inspection took place on 1 August 2017 and was unannounced. It was carried out by three inspectors, one of whom specialised in medicines.

Prior to this inspection we liaised with the local authority and reviewed information held about the service. During the inspection we spoke with the provider and the manager of the home. We reviewed medicines records for all 19 people living in the home and the care records of eight people. We also reviewed a range of documentation monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

A member of our medicines team reviewed 19 medicines incident reports for the month of July 2017. These incident reports were concerns identified by the service relating to the administration of people's medicines.

Two of these incidents could have resulted in serious consequences. One person had been given two doses of a medicine they were known to be sensitive to. Another person had recently been prescribed their medicine in a different formulation that had a brand name unfamiliar to staff. However, their original medicine also continued to be administered for a period of four days. This put the person at risk of an overdose.

Some reports showed occasions where, from stock level checks, it was determined that people had not received their medicines as had been prescribed for them. Other incidents showed that staff had not recorded that people's medicines had been administered to them. Whilst stock levels had been accurate for these incidents, it could not be determined with certainty that people had received their medicines.

Our medicines team also identified additional medicines incidents for the same month that had not been identified by the service. We found instances where the quantity of medicines in stock was higher than it should have been. This was indicative of people not receiving their medicines when they were due. Three of these medicines were high risk medicines. This meant that there could be a considerable risk to people's welfare if they were not administered correctly. We also found that the supplies of two medicines had run out.

As a result of these concerns the provider was in breach of Regulation 12 (2) (g) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

As a result of the medicines incidents that the service had identified some staff members were no longer able to administer medicines to people whilst they underwent re-training as necessary. This would take several weeks. We asked for and were provided with a medicines administration plan so we could determine whether there would be sufficient staff available that were competent to administer people's medicines to them safely. We were satisfied with the plans that the provider subsequently supplied.

During this inspection we looked around the premises as we had received information that that the premises were not always clean. We found that people's beds had been made but the bedding was sometimes soiled. One person's pillow did not have a pillowcase and the pillow was stained in several places. Some commodes were not clean, toilet brushes were visibly dirty and table surfaces were often sticky. The toilet in one person's bathroom would not flush. One person's bathroom had no towels.

These hygiene concerns put people at risk of the spread of infection. Consequently the provider was in breach of Regulation 12 (2) (h) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We checked the arrangements in place to determine whether the risks to people from falls or nutrition were being suitably managed. We found no concerns in these areas.

Requires Improvement

Is the service well-led?

Our findings

The auditing of the medicines arrangements in the home was not robust. Whilst 19 individual medicines errors had been identified during the month of July 2017 this had not resulted in a more detailed audit to identify the full scope of the concerns in this area.

The last audit had been undertaken on 28 June 2017 and had been carried out by a staff member who was no longer permitted to administer medicines to people due to errors they had made. Consequently, we could not be confident in the standard of medicines auditing being carried out. The manager told us that there was a weekly audit of medicines to check medicine stock levels against records showing how much stock should be available. However, there was no record of this.

Daily floor walks were being carried out by the manager or senior staff. However, these did not identify the cleanliness and infection control concerns that we found during this inspection.

Consequently, the provider was in breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

After this inspection the provider supplied us with an action plan to improve their medicines auditing.

The provider told us that they were seeking the advice of external medicines professionals to assess the medicines arrangements in the home with a view to making improvements.

The provider's management consultant provided practical support and guidance to the manager and staff. They were engaged for two days a week to support the provider's two homes in the area. We were concerned about the support available to the two services whilst the management consultant was on leave. The provider told us that they would be available at the services during the weeks that the management consultant was on leave.