Careline Lifestyles (UK) Ltd

Deneside Court

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

About the service
Deneside Court is a residential care home providing personal and nursing care to 40 people aged 18 plus at the time of the inspection. The service can support up to 40 people. The service provides care for people with complex needs including people with a learning disability. Care is provided over three floors.

People's experience of using this service and what we found
People told us they received their medication. Some people told us there were times when errors had been made with their medication and staff had offered apologies for these errors.

At our last inspection the provider had failed to ensure people received their medication as per prescriber's instructions. At this inspection, we identified ongoing issues.

For more details, please see the report from this inspection which is on the CQC website at www.cqc.org.uk

We looked at the systems in place for the safe management of medicines. We found the arrangements for medicines management did not keep people safe. The majority of staff we spoke with who gave people their medication, told us they had received training regarding the safe handling of medicines and they felt confident to give people their medication.

For more details, please see the report from this inspection which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update:
The last rating for this service was inadequate published 23 November 2019, when there were multiple breaches of regulations. One of the breaches was Regulation 12 – safe care and treatment.

At this inspection enough improvement had not been made and the provider was still in breach of this regulation.

Why we inspected
We undertook this targeted inspection following concerns about risks raised with CQC in relation to the safe management of medicines. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

CQC are currently trialling targeted inspections, to measure their effectiveness in following up on a Warning Notice or other specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We have found evidence that the provider needs to make improvements. Please see the Safe section of this

full report.

Follow up:
We will re-inspect the service in line with our current inspection planning methodology. We may return sooner if we become aware of increased risk to people who use the service.

Enforcement
We identified that there was an ongoing breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Details are in our safe findings below.

Deneside Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This was a targeted inspection to check on a specific concern we had received about the safe management of medicines.

Inspection team
The inspection team consisted of one inspector and one pharmacy inspector who were supported by an inspection manager.

Service and service type
Deneside Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was no registered manager at the service. A registered manager is someone who, along with the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We spoke with the local authority commissioners and safeguarding teams. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We looked at the systems in place for the safe management of medicines. We reviewed 15 people's medicines administration records (MAR) and looked at medicines storage, handling and stock requirements.

We spoke with 10 people, two nurses, three senior care staff, four care staff, two team leaders, the home's acting manager and the home's deputy manager.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check on a specific concern we had about the safe management of medicines.

We will assess all of the key questions at the next comprehensive inspection of the service.

Using medicines safely.
• Cleaning schedules were not always completed to demonstrate regular cleaning had taken place. On the day of the inspection we found the treatment room floors in the Keller and Morris units and the surfaces in the Morris unit were not clean. We found treatment room floors in the Keller and Morris units and surfaces in the Morris unit were not clean. Room and fridge temperature monitoring records were not completed in line with policy. Equipment used to support the administration of medicines, such as tablet crushers, cutters and spacer devices used for inhalers were not always clean. Clinical waste bins were not always clean, and they had not always been signed and dated as per infection control procedures.
• Staff on the Morris unit had access to policies and procedures which had been printed and placed in the treatment rooms. However, staff stated they had not read them or signed to say they understood their responsibilities with regards to the safe use of medicines.
• The home provided us with printed copies of MAR records and we found medicines were not always given as prescribed. For example, we looked at the records for one person prescribed two different antibiotics on two separate occasions. We found neither course of antibiotics had been given as prescribed. This had not been identified by the home's daily audit, therefore no actions had been taken to ensure these medicines were administered correctly. Another person was also prescribed an antibiotic. However, the quantity remaining did not match with the prescribed dose schedule and administration signatures showed the medicine had not been administered at the frequency prescribed. Antibiotic doses should be spaced evenly through the day and should be taken until the course is finished to reduce the incidence of relapse or failure of treatment.
• We looked at the records for people who were prescribed transdermal patches. We found body maps were not completed for each application to ensure rotation of patches in line with manufacturer's instructions. In addition, for one person on one occasion, a pain patch had not been applied on the scheduled day. We asked staff why the patch had not been applied they stated the person had been taken to hospital but had returned later the same day. The system had not allowed the application to be delayed and therefore the patch had not been administered leaving the person without a new patch for three days. The home's daily audit had not identified this medicine had been missed. The provider told us following this inspection that body maps were now in place.
• Although improvements had been made to support staff with the administration of some 'as and when required' medicines, these records were not always person-centred and, in some cases, there was still no

guidance for medicines which were prescribed as and when required. On one occasion medicines had changed however the guidance had not been updated. In addition, we found medicines prescribed as and when required, were not always administered as prescribed. For example, paracetamol given without a four-hour gap which is not in line with prescribed or manufacturer's instructions. Another person was prescribed a tablet for excess salivation up to three times daily however on one occasion this had been administered four times daily. Another person was prescribed a medicine at night however this had been administered during the day.

• Records for the use of thickening agents were not clear and there was no clear guidance for staff to ensure that these records were made consistently. In addition, this was not captured as part of the home's audit process.

• We looked at the records for some people who had been prescribed topical medicines by their GP. These records did not always include the name of the person or the prescriber's application instructions. We identified gaps in the recording of some people's topical medicines. For example, one person's topical medicine included instructions for this to be applied twice daily for a period of four weeks. Over a period of nine days, the topical medicine had only been applied/attempted to be applied 11 times as opposed to the prescribed 18 times. We could therefore not be sure people had their topical medicines applied as prescribed.

• The medicines audit process failed to identify the concerns that we identified during the inspection. The audit document was not tailored to all aspects of medicines management and administration. Where codes were used, or medicines were not administered no review was made to ensure actions were taken so that medicines were given as prescribed. We cross checked information we found on inspection against audit documents covering this time period and found multiple discrepancies.

• Staff spoken with told us they had received appropriate training in the safe handling of medicines. With the exception of one member of staff, staff told us they felt confident to administer people's medicines.

This was an ongoing breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.