Thurlestone Court Limited

Thurlestone House

Inspection report

Thurlestone
Kingsbridge
Devon
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Tel: 01548560737

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20 September 2016
21 September 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

Thurlestone House is a care home without nursing, providing accommodation and personal care for up to 26 older people who may be living with a dementia. At the time of our inspection there were 25 people living at the home.

Thurlestone House was previously inspected on 3 and 8 June 2016, where we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12 (safe care and treatment). We found some people did not get their medicines when they needed them; some prescribed medicines were not in stock and risks assessments did not reflect changes to people's needs. The home was rated as 'requires improvement'.

We issued a warning notice to the provider and registered manager telling them they must make the necessary improvements in relation to the management of medicines by the 24 August 2016. The provider wrote to us with an action plan telling us how they would make the required improvements. Some improvements had been made, however further improvements were needed.

We carried out an unannounced focused inspection on 20 and 21 September 2016 to check the provider and registered manager had complied with the warning notice. This report only covers our findings in relation to the warning notice served following our previous inspection in June 2016. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for residential care home on our website at www.cqc.org.

There was a registered manager in post; however they were not available at the time of this inspection. The registered manager was due to retire following this inspection. A new manager had been appointed and was working alongside the registered manager until they retired. They are referred to in this report as the manager. 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 to the way medicines were managed. These included medicines which required refrigeration were now being stored in a way that prevented unauthorised access; where people were prescribed medicines to be given "as required" guidance was provided for staff as to when this medicine should be given; records relating to medicines which were legally required to be recorded in a separate record, were maintained in a way that met the providers legal responsibilities and staff were only applying medicated creams which had been prescribed by their doctor. However, some prescribed medicine was not in stock and people's Medicine Administration Records (MARs) were not accurate and therefore staff were unable to assure themselves people were receiving their medicines as prescribed.

Records relating to people's care had improved. One care record was not complete and did not provide

guidance for staff. However, staff understood what this person's needs were and how to meet them. Other records were accurate and up to date, and gave guidance to staff.

Since the last inspection, the provider had introduced a new falls management process which identified action staff should take following an accident/fall. Whilst some records were not completely up to date, staff were taking action to protect people from risks such as falling, and from behaviours that might be harmful.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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

Some aspects of the service were not safe.

The processes in place to manage medicines had not ensured people received their medicines as prescribed by their doctor.

Care records were not always complete and did not provide clear guidance for staff to understand how to meet each person's specific care and support needs.

Risks to people's safety had been assessed and action had been taken to effectively mitigate these risks.

Medicines were stored safely and securely.

Thurlestone House

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an unannounced focussed inspection on the 20 & 21 September 2016. This inspection was carried out to check that improvements to meet legal requirements planned by the provider following our comprehensive inspection on the 3 & 8 June 2016 had been made.

The inspection was undertaken by one adult social care inspector. Prior to the inspection, we reviewed the information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to tell us about by law. We looked at the action plan the provider had sent, which told us what action they had taken following our comprehensive inspection in June 2016.

During the inspection, we focussed on one of the five key questions we ask about services: is the service safe? At our previous inspection we rated this key question as requires improvement. This was because the service was not previously meeting legal requirements in relation to this area.

We looked at the care of five people in detail to check they were receiving their care as planned and reviewed how the service managed people's medicines. We spoke with two members of staff, the manager, a senior manager and the company director.

Requires Improvement

Is the service safe?

Our findings

Thurlestone House was previously inspected on the 3 and 8 June 2016. We found that people's medicines were not being managed safely and risks to people's safety had not always been managed appropriately. This meant there was a breach Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We issued a warning notice to the provider and registered manager telling them they must make the necessary improvements by the 24 August 2016. The provider wrote to us with an action plan telling us how they would make the required improvements.

At this inspection, we inspected the service against one of the five questions we ask about services: is the service safe? At our previous inspection we rated this key question as requires improvement; this has not changed following this inspection. Although we found the provider had complied with the requirements of the warning notice and improvements had been made in some areas, further improvements were needed to ensure that people's medicines were managed safely.

People' medicines were not always managed safely; we looked at the Medication Administration Records (MARs) for nine people and found stock management had not improved sufficiently to determine that people were receiving their medicines as prescribed. Although the manager assured us people were receiving their medicines, records did not always match with what was held in stock. Medicine Administration Records (MARs) were not always completed accurately and when one person's stock of medicine had run out, staff had borrowed stock from another person' while they waited for this person's medicines to arrive. The manager took immediate action to address our concerns.

This was a breach of regulation 12 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

We looked at the care records for five people in detail and found that one person's individual needs had not been assessed or planned for. Records showed this person had been admitted to the home seven days prior to our inspection for respite care. This person did not have a care plan and the home had not assessed any of the risks associated with providing care and support for this person during their stay. For example, the home had not carried out any assessment of this person's general health, nutrition, skin integrity, personal care or mobility. Records did not contain any guidance for the staff on how to meet this person's specific needs or support their well-being during their stay.

We raised this with the manager who said this had been an oversight on their part. They assured us staff had been given all the information they needed to provide care and support for this person in a safe way, but they hadn't had time to complete this person's care plan. The manager told us this person had full capacity and was capable of directing their care and support. Staff we spoke with described how they supported this person during their stay but said this information was only shared verbally through daily handovers and the person's daily records sheets.

This was a breach of regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

At our previous inspection we found the provider did not have suitable arrangements in place to ensure that risks were being managed effectively. For example risk assessments were not always up to date or did not reflect changes to people's needs; risks associated with people's behaviour had not always been identified and therefore steps had not been taken to mitigate these risks. We looked at people's care records in detail and found improvements had been made.

Following our inspection the provider introduced a new falls management process which included a flow chart for staff to follow. The flow chart set out each step of the process and identified what action staff should take and which documents needed to be completed, reviewed or up dated. For example following a fall staff were directed to complete an accident form, update the person's falls diary, review the person's falls risk assessment, and document any action taken within the person's care plan.

We reviewed the accident and incidents records for the previous month. Records showed that some staff were not fully following the new falls management process. For example one person had fallen three times the previous month. However this person's care records were only updated on one occasion. Staff we spoke with did not all fully understand the new process or their responsibilities in relation to the documentation they were required to complete. We raised this with a senior manager who told us the new process had made a positive impact in the way the home managed falls and reduced risks; however the new process still needed time to fully embed. They assured us they would continue to monitor and review the new process and meet with staff to provide further training.

Records showed risks associated with people's behaviour were being identified and appropriately managed. The manager discussed all aspects of people's care during daily handovers and had implemented a new communication book which staff used to communicate important information between shifts. The manager reviewed this information daily and where concerns were raised; action was immediately taken to address them. For example, records showed staff had recently raised a concern about one person's behaviour following an incident between two people living at the home. The manager had introduced a monitoring chart following advice from health care professionals and updated the person's care plan. Records showed staff had a clear plan in place to minimise this person's distress and reduce any potential risks to others.

Each person had detailed risk assessments, which covered a range of issues in relation to their needs. For example risks associated with skin breakdown, poor nutrition and mobility. People's records showed their risks assessments were being reviewed regularly. The registered manager had undertaken regular accident and incident audits in order to identify any potential patterns and trends.

At our previous inspection people's medicines were not being managed safely. Medicines which required refrigeration were not being stored in a way that prevented unauthorised access. Where people were prescribed medicines to be given "as required" there was no guidance for staff as to when this medicine should be given; records relating to medicines which were legally required to be recorded in a separate record, were not maintained in a way that met the providers legal responsibilities and staff were applying medicated creams to people which did not correspond to the ones they had been prescribed. During this inspection we found that action had been taken to address these issues.

We observed the lunch time medicines round and saw people received their prescribed medicines on time, in a safe way. People were given the time and encouragement to take their medicines at their own pace. Staff stayed with people to ensure they had taken their medicine before completing the Medication

Administration Records (MARs). There was a safe system in place to monitor the receipt of medicines held by the home and medicines were disposed of safely when they were no longer required. MARs identified people's allergies and protocols for 'as required' medicines (PRN). Where medicines required to be stored at a specific temperature the home had purchased a new medicines fridge. This was secure and the temperature was checked daily.

Where people had been prescribed a medicated cream, these were dated when opened, which meant staff could easily check these were still safe to use. Each person had clear guidance and body maps indicating which creams should be use, when and where. We checked people's medicated creams and found that staff were only applying medicated creams which had been prescribed by their doctor. Improvements had been made in the procedure for administering medicines which were legally required to be recorded in a separate record. Following our previous inspection all staff had undertaken medication training via an external provider.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected by the safe management of medicines. Regulation 12(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not maintained an accurate, complete and contemporaneous record of each service user. Regulation 17 (2) (c)