Golden Age Management Limited

Attwood's Manor Care Home

Inspection report

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Date of inspection visit:
19 December 2016

Date of publication:
07 February 2017

Ratings

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

Summary of findings

Overall summary

The inspection was unannounced and took place on the 19 December 2016. the purpose of the inspection was to follow up on continued concerns about medication practices within the service and to ascertain that people were safe.

There is currently no registered manager at the service but an interim manager has been appointed. 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.

The service is registered for 65 older people who require assistance with personal care but due to the suspension in place by the Local Authority the service had less than 40 people at the time of this inspection.

At this inspection we found a continued breach with Regulation 12, Safe care and treatment. We shall be inspecting the service again shortly.

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 is not safe.

People's medicines were not effectively managed.

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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.'

We carried out a focussed inspection to this service on the 19 December 2016 which was unannounced. The inspection took place because we had continued concerns about this service since it was rated inadequate following the last inspection on the 6 and 9 September 2016. The service was placed into special measures and the Local Authority placed an embargo on the service to ensure they could not take any new admissions until they could demonstrate they could provide safe, effective care. They have continued to monitor the service and investigate any reported safeguarding concerns. The findings of both safeguarding investigations and monitoring visits have been shared with the CQC and joint meetings have taken place. Due to continued concerns raised about medication practices a pharmacy inspector working on behalf of CQC inspected the service to look at their practices. A further inspection is planned to check compliance against the services submitted action plan which was submitted in December 2016. .

The inspection was undertaken by a pharmacy inspector who looked only at medicines.

Inadequate

Is the service safe?

Our findings

During previous inspections we found that medicines were not being managed safely and at the last inspection SAFE was rated as inadequate. We have not changed the rating. This inspection was carried out to identify whether the issues we found had been addressed.

We found some improvements in the availability of medicines and the way they were administered and recorded, but other problems had not been addressed.
The provider had introduced a new medicines policy. It was not always followed in practice, for example the process for managing medicines to be given as and when needed. The policy set out the need for "full and precise instructions" on how the medicine was to be used, including the dose, frequency and maximum dose. We found people were being given pain relief medicines with no information to guide staff on how to administer the medicine consistently and correctly. Staff had access to pain assessment tools but there was no record to show that they were being used and they did not provide guidance on how much medicine to give. One person was being given an inhaler with no information on the dose or how many times a day it could be used. There was a risk that this person was getting to much or too little of their medicine. There were two places to record the use of 'when required' medicines and they weren't both completed every time so it was not easy to see how much medicine had been administered.

There was a separate record for the application of creams and we saw that diagrams to show where to apply each cream were now in use. However the records we looked at for two people had not been completed at all for the last four days. We could not be sure that creams were being applied as prescribed.The provider told us they would start to check the records at the end of each shift to make sure they were being completed.

Some people were looking after their own medicines and risk assessments had been completed to assess whether they could manage them safely. We found that the risk assessments were not being reviewed monthly in line with the policy. We saw that one person was managing their own inhalers. When we looked in their room we saw that they were not stored as described in the risk assessment. We found a new inhaler which was not recorded on the medicine chart and had not been used. The staff we spoke with were unaware that the person had been prescribed a new inhaler and had not recorded it on receipt. There was no information to show whether this inhaler was a replacement for an existing one, or to be used in addition. The person was not being supported to use their inhalers as prescribed. The provider told us they would contact the prescriber to confirm how the new inhaler should be used.

At a previous visit we saw that the medicines chart did not include a record of allergies.The chart had been updated to include allergy status but it did not include details of which medicines the person was allergic to. One person had 'yes' recorded against allergies but we had to look at their electronic care plan in the office to find out that they were allergic to medicines containing penicillin. This information was not easily available to the staff administering medicines so there was a risk that they might administer a medicine which would cause an allergic reaction.

Medicines were securely stored and the temperatures of the storage room and fridge were recorded regularly, however as at our visit in May, the fridge thermometer wasn't reset after each reading to show that the temperature was within the correct range each day. Staff were recording the intended temperature range, rather than the actual maximum and minimum temperatures shown on the thermometer as specified in their policy. The provider had no records to show whether medicines were stored within the manufacturer's recommended range. They told us they would provide training for staff on how to use the thermometer.

We looked at the records for people who were using medicinal skin patches. The records showed where the patches were being applied to the body. We saw that patches were not always being applied to different sites each time in line with the manufacturer's guidance, which could result in unnecessary side effects.