Finest Care Limited

Clifton House Residential Care Home

Inspection report

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Overall summary

We carried out an unannounced comprehensive inspection of this service on 12 and 19 January 2015. A breach of legal requirements was found because medicines were not being managed in the right way and staff did not follow the requirements of the Mental Capacity Act 2005 (MCA) where people lacked capacity to consent to their care. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to these breaches of the regulations.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met the legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Clifton House Residential Care Home on our website at www.cqc.org.uk.

We found the assurances the provider had given in the action plan had not been met with regard to the management of medicines. This meant the registered provider had continued to breach the regulations with regard to medicines management. Medicines were not always managed safely for people and records had not been completed correctly. People did not receive their medicines at the times they needed them and in a safe way. Medicines were not obtained, administered and recorded properly.

You can see what action we told the provider to take at the back of the full version of the report.

We found the assurances the provider had given in the action plan had been met with regard to the requirements of the MCA. People had been assessed under the MCA and where required the local authority had granted Deprivation of Liberty Safeguards (DoLS) authorisations. Specific MCA training had been provided to raise staff awareness and help them provide the support people who lack capacity need with making decisions.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
We found that action had not been taken to improve safety. We found the registered provider had continued to breach the regulations with regard to medicines management. Further improvements needed to be made in regard to management of medicines.

Is the service effective?
We found that action had been taken to improve the effectiveness of the service. We found staff were now following the requirements of the Mental Capacity Act 2005 (MCA).

We could not improve the rating for: is the service effective; from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Clifton House Residential 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 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 undertook an unannounced focused inspection of Clifton House Residential Care Home on 22 September 2015. This inspection was done to check that improvements to meet legal requirements the registered provider planned had been made following our comprehensive inspection on 12 and 19 January 2015. We inspected the service against two of the five questions we ask about services: Is the service safe and Is the service effective? This is because the service was not meeting some legal requirements.

The inspection was undertaken by an adult social care inspector and a pharmacist inspector. During our inspection we looked at medicines records, how medicines were managed and care records for four people using the service. We spoke with the registered manager and two senior care staff.

Is the service safe?

Our findings

During our last inspection in January 2015 we found medicines were not managed safely or recorded properly. Medicines records were not completed correctly. We found there were more medicines in stock than the administration records indicated and guidance for 'when required' medicines was not kept up to date and information was missing for some medicines.

We reviewed the action plan the provider sent to us in April 2015. This gave assurances action would be taken to improve the quality of medicines records and guidance. The provider told us in their action plan they had already made the required changes to be compliant with the regulations.

We found the registered provider had continued to breach the regulation as the assurances given in the action plan had not been met. We looked at how medicines were handled and found the arrangements were not always safe. Records relating to medicines were not completed correctly placing people at risk of medication errors. For example medicine stocks were not properly recorded when medicines were received into the home or when medicines were carried forward from the previous month. This is necessary so accurate records of medicines are available and care staff can monitor when further medicines would need to be ordered. For one person a cream was not available and could not be used as prescribed. This meant appropriate arrangements for ordering and obtaining people's prescribed medicines was failing, which increases the risk of harm.

When we checked a sample of medicines alongside the records we found that four medicines for four people did not match up so we could not be sure if people were having their medicines administered correctly.

Arrangements had been made to record the application of creams by care staff. However, these records were sometimes missed. This meant that it was not always possible to tell whether creams were being used correctly.

We found that where medicines were prescribed to be given 'only when needed,' protocols to inform staff about when these medicines should and should not be given, were not always available. Whilst staff were able to tell us how the medicines were given, this information was not recorded in detail. This information would help to ensure people were given their medicines in a safe, consistent and appropriate way.

This was a continuing breach of Regulation 12 Heath and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were kept securely. Records were kept of room and fridge temperatures to ensure they were safely kept. Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss.

Is the service effective?

Our findings

During our last inspection in January 2015 we found staff were not following the requirements of the Mental Capacity Act 2005 (MCA). The Care Quality Commission (CQC) is required by law to

monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests.' It also ensures unlawful restrictions are not placed on people in care homes and hospitals.

We reviewed the action plan the provider sent to us following our last inspection. This gave assurances people would be assessed in line with MCA, where required DoLS authorisations would be requested and MCA training provided for staff. The provider told us they would be compliant with the regulations by the end of April 2015.

We found the assurances the provider had given in the action plan had been met. The registered provider had taken action to comply with the MCA. The registered manager told us and care records confirmed DoLS authorisation had been granted for three of the thirteen people using the service. Applications had been submitted to the local authority following a review of all people using the service. Where people had been assessed as lacking capacity and a DoLS authorisation had been granted, a specific care plan had been developed. This provided staff with guidance about how to support people with decision making. For example, care plans described how staff should support people to make decisions through offering choices and understanding their preferences.

The registered provider had taken action to increase staff understanding and awareness of MCA. The registered manager told us that training was not currently available through the local authority but that staff would attend this training when available. In the meantime the registered provider had enrolled staff onto specific MCA and DoLS training provided through a private training organisation. At the time of our focused inspection most staff had completed this training. The registered manager had set up a 'DoLS file' which was available to staff as a learning tool. This included guidance about DoLS and copies of various forms and documentation staff may encounter when working with people. Minutes of staff meeting showed MCA and DoLS had been a topic for discussion at a recent team meeting.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

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 fully protected against the risks associated with medicines because the provider did not manage medicines appropriately. Regulation 12 (2) (g).

The enforcement action we took:
We have issued a warning notice to the registered provider and the registered manager.