Central and Cecil Housing Trust

Queens Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 22 June 2017 and was unannounced.

Queens Court is a care home with nursing that is based in Windsor, Berkshire. Queens Court is one of eight care home services the provider currently operates. The service is registered to provide residential and nursing care for up to 62 people. The service is for older adults, some of whom have dementia. At the time of our inspection, 46 people used the service. Queens Court provides care across three floors; two floors accommodate people for nursing care and one floor provides residential care.

The service must have a registered manager.

At the time of the inspection, there was no registered 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.

Our last inspection was conducted on 12 July, 13 July and 14 July 2016. The key question 'Is the service safe?' was rated as 'requires improvement' and the overall rating for the service was 'requires improvement'.

The purpose of this inspection was to examine the safety of people's medicines management. This inspection looked at only one key question; "Is the service safe?" The rating remains as 'requires improvement' for this key question. The overall rating has not changed.

The management of medicines at Queens Court was not safe. Medicines were not ordered in time from the GP and the community pharmacy. Records regarding medicines were incomplete, missing or damaged so that accuracy of administration could not be established.

Medicines were stored in appropriate areas, but the storage rooms were frequently beyond the recommended maximum temperature. The service and management had not taken action to ensure medicines rooms were at an appropriate temperature.

Medicines errors were reported by staff. However, an accurate record was not always maintained and investigations were not robust. Learning from medicines incidents to prevent recurrence was not demonstrated.

Relatives told us they did not have enough information provided to them about people's medicines. They told us they witnessed medicines being given but did not know what the medicines were for.

The disposal of medicines was not always appropriate. We found evidence that medicines were sometimes disposed of incorrectly. Records of medicines disposals and destruction were not robust and checks by

management for controlled drugs were lacking.

Staff did receive training about medicines safety and administration. Staff also completed competency assessments to check they could safely deal with people's medicines.

We found one 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

The service was not always safe.

People's medicines were not safely managed.

People received their medicines but records were not clear.

Medicines incidents investigations and audits required improvement to ensure people's safety.

The disposal of medicines was not always satisfactory.

Relatives told us they did not receive enough information from the service about people's medicines.

Queens Court

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.

This inspection took place on 22 June 2017 and was unannounced. We conducted telephone calls with relatives on 22 June, 23 June and 24 June 2017.

This was a focused, responsive inspection. The notification of an incident indicated potential concerns about the management of risks. This prompted the inspection to check the service's compliance with medicines management and if people were safe.

The inspection team comprised of one adult social care inspector, a pharmacist inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our Expert by Experience was familiar with the care of older adults and dementia.

Before the inspection, we did not ask for the submission of a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we already 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 send us by law. We also looked at feedback we received from members of the public, local authorities, the clinical commissioning group (CCG), GPs and the community pharmacy.

During the inspection we spoke with the provider's operations manager, the quality and compliance manager and the clinical services manager. We also spoke with the service's clinical lead, deputy manager, two registered nurses, five care workers and the administrator.

We spoke with multiple people who used the service and 16 relatives, friends or visitors. We looked at 11 people's medicines administration records (MARs), medicines audits, the medicines policy, controlled drugs registers, and other records associated with the safe management of medicines. We asked the provider to send further documents after the inspection and these were included as part of the evidence we collected.

We observed staff that administered medicines as part of our inspection.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 12 July, 13 July and 14 July 2016, we rated this key question as 'requires improvement.' Although we found the management of medicines had improved after our inspections, continued improvement was required. We have inspected the regulation about safe care and treatment for people and found that the service failed to sustain improvements in the safe management of medicines. We consider a breach of the regulation has occurred. Our rating for this key question remains as 'requires improvement'.

Prior to our inspection, we received feedback from a number of stakeholders that worked with the service. They expressed escalating concerns about the safety of people's medicines management for a number of reasons. Examples of issues they told us about included that medicines were not ordered in time or inappropriately ordered, that records of medicines administration were incorrect, that medicines were not stored safely and that medicines were discarded incorrectly. Some stakeholders had worked with the service over the prior twelve months in an attempt to improve practices by staff. There was evidence that some improvements were completed. This included a decrease in overstocking of medicines for people. However, stakeholders explained to us that from February 2017 onwards, the management of medicines had placed people at risk of harm. We reviewed evidence we obtained from stakeholders which demonstrated they worked with the service and management to ensure safe management of medicines. However, even with the collaborative working with external parties, the service failed to ensure some aspects of medicines management were safe.

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

We asked people who used the service for feedback about their medicines administration. People we spoke with were uncertain about what medicines they took and whether staff administered them correctly. We spoke with 16 people's relatives. They were able to provide feedback, but also had limited knowledge about people's medicines. One relative said, "I think she (the person) gets her medication I can't be sure. I hope she does. She is on quite a large number of medications but I don't know what they are all for. It's difficult to find anyone to talk to. There's no main point of contact." The next relative stated, "I check the book in his (the person's) room when I go down and it says he is given them, so I hope that's right but I don't always see it happen. I get no communication about what goes on with him unless I go and ask for it." Another relative told us, "She's (the person) not always monitored when taking meds so doesn't always swallow them." Other comments from relatives included, "I only visit every [few] weeks so I can't tell you if he (the person) gets his meds or not and the home won't discuss anything with me", "I have no idea what medication she (the person) is on or what it's for or if she gets it. They don't tell you anything", and "We come in [often] and sometimes she (the person) is given her tablets in front of us, so I'm positive she gets it. Sometimes if she's in a bad mood she won't take them so how they get round that I don't know."
Many relatives we spoke with felt their lack of information about people's treatment was due to poor communication from staff about medicines.
There was a medicines policy dated June 2016 in place. The 60-page document included instructions for

staff about medicines management, blank competency assessments and audit tools. We noted very few staff who administered medicines had signed to state they had read the content of the policy. The policy was not specific to the service. It was not adapted to include details of how the service managed medicines locally, and lacked specific information about the local GPs and community pharmacy.

Staff who administered medicines included registered nurses for the two floors where people received nursing care, and team leaders (care workers) on the residential floor. Staff were required to undertake annual training about medicines awareness and handling medicines before they were permitted to administer medicines to people. We found different types of medicines training were offered by the service and completed by staff.

We saw 'medication awareness' was a basic foundation type of training which all staff that provided care or support to people were required to complete. This course was undertaken via e-learning during induction or soon after a staff member commenced work at the service. When we checked staff training records, we found 39 out of 43 staff had completed this course. We found the 39 staff had completed the training within the year leading to our inspection.

The next type of staff training was 'medication administration'. We found this was a practical course with face-to-face teaching about medicines safety and risks, medicines management, medicines administration and the handling of medicines errors. We saw from the training records that 30 staff had completed this training, with five staff still required to undertake the course. The 30 staff had completed the 'medication administration' course within one year prior to our inspection.

We checked how many staff who actively administered medicines had a completed competency assessment. This is a tool that an assessor uses to observe the practice of the staff member and record the ability of the worker to perform the task safely. The deputy manager told us that a competency assessment required completion by 15 of the service's staff. We saw evidence that thirteen staff had documented competency assessments, but the records for two staff were not located. One staff member's medicines administration competency assessment was overdue. This meant some staff who administered medicines may not have received observed assessments to check their competency. This could lead to the unsafe handling of medicines if the staff member did not have the knowledge and skills to properly perform administration of medicines.

We observed the practice of staff who administered medicines. Although staff wore red tabards which indicated they were administering medicines, we noted they were frequently interrupted by other staff. This led to distraction of the staff member carrying out the medicines round, delayed people receiving their medicines in a timely way, and increased the risk for medicines errors. We noted staff used the correct procedure for administration of the medicines from the trolley and cupboard. However, we observed staff did not wash their hands or sanitise them between administrations of each person's medicines. This increased the risk of cross-contamination of infections between people.

Medicines were stored securely in medicine trolleys and rooms. At the time of our inspection, the trolleys and cupboards were organised and not overstocked. However, we found evidence that prescribed items had expired. The items were not disposed of. Stock we viewed included urine test strips, which expired in February 2017, skin creams which expired in March and August 2016 and catheter lubricant that expired in March 2017. As the expired items were still present, there was the potential they would be utilised by staff for people who used the service.

We looked at the temperature of the three rooms and three fridges where medicines were stored. We found

upon entering all three medicines rooms, the ambient temperature was hot. Staff who accompanied us into the rooms agreed with us. Only one of the rooms had an air conditioner installed. Staff told us this was not working. When we asked, staff told us they had reported this multiple times to management. However, the air conditioning was not repaired to ensure a safe room temperature for the medicines. We alerted the provider's senior management about the room temperatures three times during the inspection. They noted our feedback and contacted a maintenance contractor to attend to the air conditioning.

The room and fridge temperatures were checked every 24 hours, by night shift care workers and registered nurses. We looked at the records from January to June 2017. Staff had completed the record forms consistently. The fridge temperatures were within the recommended range and staff we spoke with knew the correct procedure for resetting the digital thermometer every 24 hours. We viewed records that showed the three medicines room temperatures exceeded the recommended maximum temperature of 25°C multiple times. We found sometimes this was recorded for multiple consecutive days. There was no record that management was informed or that the community pharmacist was consulted for advice. On the day of our inspection, we found the temperature of the rooms was 29°C or 30°C. One room thermometer was lying on a bench and not immediately visible because it was covered by documents. The high room temperatures over time meant that medicines being administered to people may have been damaged by heat, rendering them less effective or ineffective when consumed .

Medicines supplies were not always properly ordered in time. Evidence we looked at showed staff had requested medicines late in the ordering cycle. This meant local GPs were given too-short notice to prescribe the medicines, that prescriptions reached the community pharmacy belatedly, and that the medicines often reached the service so late that staff were pressured to count and reconcile the medicines. This was confirmed by stakeholders and staff we spoke with. This placed people at risk of not having medicines in stock for administration on time for the start of a new monthly cycle.

We could see that staff recorded the quantity of medicines in stock at the start of the month, but they did not do regular stock counts throughout the month. We saw stock discrepancies for codeine and paracetamol tablets, diazepam tablets, high strength codeine and paracetamol tablets, loperamide capsules and constipation powder sachets. Without counting stock, some medicines were unaccounted for. It was not possible to determine whether people had received the correct amount of medicines or whether the medicines were elsewhere.

The dispensing pharmacy supplied the medicines administration records (MARs). MARs are used to record when staff have administered or not administered medicines. The MARs were not always complete for people that received 'as required' medicines. 'As required' medicines are for occasional use. We found there were multiple blank boxes on all MARs for 'as required' medicines, so it was not possible to determine if the person refused the 'as required' medicine or if it was given but not signed for as administered by staff. This showed inconsistency in recording the administration of 'as required' medicines between staff. Staff we spoke with were not clear on how they should be recording 'as required' medicines.

'As required' medicines routinely have protocols in place so that staff administering the drug know when the person can safely have a dose. Although the service had some 'as required' protocols in place to support staff to administer the medicines, they were not written for all people that received 'as required' medicines and some protocols had missing details. One person had controlled drugs (medicines that require greater controls and care when administering) prescribed 'as required' but there were no protocols or additional instructions recorded to guide staff how to safely and effectively administer the medicines. This meant staff may have inadvertently given less medicine than needed, or too much. Without all of the 'as required' protocols, staff were also unable to have a GP or pharmacist review the ongoing use of the medicine over

time. There was a risk that people had 'as required' medicines that they no longer required .

The service placed a list of people's medicines alongside their MARs in a folder. We found the staff did not keep the information updated. We saw discrepancies between the MARs and the list of medicines, which could cause errors. Staff may have reviewed people's medicines lists and determined a person was taken a medicine when it was discontinued. In addition, staff could interpret the document as a comprehensive, accurate list of the person's medicines. This could create errors when the person was placed on new medicines, short does of medicines (like antibiotics) or where dosages or frequencies of medicines changed.

People sometimes required medicines to be administered covertly (without their knowledge). Staff completed mental capacity assessments and deprivation of liberty applications required by the Mental Capacity Act 2005. However, one person did not have the covert medicine best interest decision reviewed for 17 months. Best practice guidelines state covert medicine decisions should be reviewed regularly and the provider policy stated that the review should occur every 6 months. There was limited information on how to administer the medicines covertly. The best interest decision stated 'in food' and the care plan stated 'in liquid'. The failure to review the covert medicines administration regularly meant that the person's best interests were not taken into account. In addition, without clarity in how to administer the medicine covertly, staff could have administered the drug incorrectly, reducing it's effectiveness for the person.

Liquid medicines require the date of opening to be recorded on the bottle or box, so that staff know when to dispose of the container and start a new one. This is because over time, the medicine bottle is susceptible to microorganisms or the effectiveness of the medicine decreases. We found evidence that staff did not always write the date of opening on the medicines bottle or box. We examined one medicine where the date of opening was not recorded. Staff did not know when it was opened and from records it was also not possible to determine the date it was opened. There was the potential the medicine was used for too long after opening.

The service did not always respond to NHS England patient safety alerts. For example, staff were not aware of the alert about accidental ingestion of thickening powders (used to thicken fluids for people with swallowing risks). Actions for this alert should have been completed in March 2015 but we saw thickening powders stored within easy reach of people. As some people at the service had dementia and wandered, they could have accessed the powder in the absence of staff supervision. Accidental ingestion of the powder could cause complications or serious harm to the person.

We checked the disposal of medicines waste. Medicines must be disposed of in different ways, depending on the type of medicine. Medicines no longer required were separated from useable stock. Staff recorded medicine disposals in a record book and a second person witnessed the disposal. We saw evidence that the provider had a formal contract in place for a medicines waste company. We looked at records which showed some medicines were collected as part of clinical waste, and these were taken away for incineration. The service also had boxes in place in medicines rooms, where some medicines were placed when they required to be returned to the community pharmacy. These boxes were used correctly.

We had concerns about the disposal of unwanted controlled drugs. As controlled drugs have strict management requirements, the disposal of them is subject to stringent standards. When we examined records for controlled drugs, we found that compliance with legislation was not always followed. In some instances, staff followed the correct procedure of recording and disposing of the medicine in the 'denaturing' kit (making the drug unusable). However, we found examples where controlled drugs were not managed or disposed of correctly. An example was where a person had moved out of the service two

months before. We found the controlled drugs register showed the medicines were disposed of . The person's entire controlled drugs supply was still stored in the controlled drugs cupboard. There was the potential for the medicines to be inappropriately taken away from the service by staff as the balance appeared to be zero stock. Checks by managers at the service failed to detect the balance in the controlled drugs register did not match what was stored in the medicines cupboard.

We identified some example of poor record-keeping by staff that administered medicines. MARs and other documents, like the controlled drugs registers, must be legible and not contain errors. The provider's policy clearly explained the procedure for staff to follow if a medicines documentation error occurred. However, we found this was not followed every time. For example, in one MAR chart where the person received a high risk medicine, a medicines error had occurred. Staff members had crossed out the administration error multiple times, wrote over the top of prior entries, and altered the entries in other ways. This made it impossible to understand what doses of the medicine the person was administered.

In the controlled drugs registers, there were errors in the way medicines were recorded. We examined the content of six books. In one instance, we saw staff had recorded a person's controlled drugs were given to a relative. There was no entry made in the controlled drugs book to say why this had occurred. Staff we spoke with were unable to explain the reason the relative took the controlled drugs away . In another entry of a controlled drugs register staff had recorded the medicine was returned to the pharmacy followed immediately by it being destroyed and then that a dose was given to the person who used the service. It was not possible to determine what had actually occurred with the controlled drug. Another example included single lines in the controlled drugs register left blank, so that staff had the potential to enter additional information after the medicines were disposed of or destroyed. We saw one example where the person's controlled drug was recorded as disposed of instead of as administered. One person's MAR chart, a person prescribed morphine twice a day had five missed signatures by staff within one week . It was not possible at the inspection to determine if the person had received their analgesia.

There was no accurate record of the number of medicines incidents or errors. Registered nurses and care workers we spoke with told us they willingly reported medicines incidents. One staff member told us of an error that they made, and how they had learned from their own self-reflection to prevent the error recurring. Although the incident involved a high risk medicine, no known harm occurred to the person who received the medicine. We found staff were not treated punitively when they reported medicines incidents. In some examples where medicines incidents were reported to management, a meeting or supervision with the staff member occurred. This was a way for the management and staff member to review the factors leading up to the incident and consequences of the error. However, not all medicines incidents were reported. This meant the management did not have an accurate record of how many medicines incidents had occurred over time. When we asked about incidents, we were provided with one form which documented staff missing signatures on a MAR. There was no supporting documentation to show how the issue was addressed, when the matter was resolved or who took action to make corrections.

We examined another example where a medicines incident occurred. A person was given a medicine dosage that was not according to the prescription. The medicine incident was reported. When we asked for evidence that the incident was investigated, we were provided with an e-mail, a copy of the MAR and two staff statements. There was no investigation report or actions documented to prevent repetition of the error. There was no communication with staff about risks related to the administration of the medicine. We found another person was subject to the same error after the initial incident with the medicine. Although there was no reported harm to the person, and documentation about an investigation into the incident was not available. Where alleged staff misconduct occurred with relation to medicines, investigations did occur. We found the investigations commenced too late, risks to people from the alleged staff misconduct were not

considered, and the provider failed to report the matters to relevant regulators. Staff were allowed to continue to administer and manage medicines whilst under investigation. This meant people and their medicines were at risk from staff that may not have always followed correct procedures or complied with relevant legislation.

We inspected the service's, managers' and provider's auditing of medicines management. We found this was inadequate. We saw several types of checks were in place, but not consistently used. We also found that where failures or areas for improvement were identified, they were not always actioned or followed up.

Checks of controlled drug balances were completed by care workers and registered nurses at morning and night shift changeovers. These were recorded in a book, but not the controlled drugs register. Although staff counted the controlled drugs, checked the balance in the cupboard matched the register and signed the book together, there was no evidence that management conducted independent checks of the balances regularly. There were no missing controlled drugs. However, routine checks by managers or staff not involved in the administration of the medicines is recommended to ensure that any errors are detected as soon as possible. Staff we spoke with told us they would report controlled drug count discrepancies to the management immediately.

We looked at 18 copies of the 'MAR audit tool'. We were told these were daily checks of one person's medicines management. The checks were undertaken by the clinical lead, registered nurse or team leader (care worker). The check examined a person's medicines profile sheet and MAR chart. Although we were told the tool examined one person's medicines safety and records each day, we found they were not completed on some days. We saw that in some of the records, staff recorded 'yes' and 'no' to questions, without evidence stated, as the document required. We also saw some staff had completed the audit in a detailed manner, answering each question and providing explanations of the evidence they viewed. In some of the audits, we saw questions were not answered, but there was no explanation of why they were left blank. We noted that the section concerning copies of people's prescriptions was the most commonly unanswered question. Where areas for action were identified, for example taking a new photo of the person for identification, these were not recorded as completed.

A 'managers audit' was completed on 23 March 2017 by the home manager at the time. Areas where action was required by staff or management were required. For example, it was recorded that issues highlighted in the prior 'managers audit' were not completed, that staff had failed to check the blood glucose monitors, that the correct codes on MARs were not always used and recording discrepancies were found. No record was made in the audit of how or what corrections to practice should occur However we viewed an action plan from the provider which was reviewed on 20 April and 19 May 2017. The action plan was not specifically for medicines management, but contained a section related to medicines. We saw there were nine actions with various dates for completion and responsible staff recorded. Some items signed off as complete, such as 'as required' medicines protocols, were not complete at the time of our inspection. Some actions, such as completion of additional training using work books, were marked as complete but there was no evidence any staff had completed them. Without robust, frequent audits and checks by the service, its management or the provider, we could not be assured that medicines management was safe and that errors would be detected or acted on.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. The registered person did not ensure the proper and safe management of medicines.