142 Petts Hill Care Home

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Inspection report

142 Petts Hill
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05 July 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 5 July 2017. The last inspection of the service took place on 22 February 2016, when we rated the service as 'Good' overall but 'Requires Improvement' in the key question, 'Is the service safe?' and identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to the management of medicines.

At the inspection of 05 July 2017, we checked if the provider had put in place adequate systems to make the necessary improvements. We found the provider had not made the necessary improvements in the way they managed people's medicines, therefore risks to people's health and safety remained.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for 'Petts Hill Care Home' on our website at www.cqc.org.uk.

Petts Hill Care Home provides accommodation, support and care for up to three people who have mental health needs. At the time of our inspection, there were three people living at the service.

The home is family owned through a partnership. There was a registered manager in post at the time of our inspection. 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.

Medicines management remained unsafe. The provider had improved the way in which medicines were stored. However, records still did not ensure that a clear audit trail was provided to confirm people received their medicines as prescribed. The provider had still not put adequate systems in place to monitor the management of medicines. This resulted in people being at risk of not having their medicines properly administered.

We are proposing to take further action against the provider for the breach of regulation in regards to safe care and treatment. We will add full information about CQC's regulatory response at the back of the full version of the report 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?

Requires Improvement

The service was not always safe.

The provider has improved the storage of medicines but they had still not improved the management of medicines adequately to protect people from any associated risks.

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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.

This inspection took place on 05 July 2017 and was unannounced. This inspection was carried out by one inspector. We inspected the service against one of the five questions we ask about services: is the service safe? This is because we had identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at our last inspection in February 2016. This related to the management of people's medicines.

During the inspection, we reviewed the medicines management system, including the Medicines Administration Record (MAR) charts for all three people, the storage of all prescribed medicines and their expiry date, and the staff training in relation to medicines administration.

We also spoke with the registered manager, the assistant manager and a senior support worker.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of 22 February 2016, we found a breach of regulation in that the provider did not always manage people's medicines safely. Following the inspection, we requested that the provider send us an action plan by 15 April 2016, but we did not received this. At this inspection, we found that the provider had not made the necessary improvements.

We looked at the storage, recording of receipt, administration and return of medicines and records in relation to the management of medicines.

At our last inspection, we had identified that MAR charts did not include a record of the number of medicines received at the beginning of each monthly cycle. At this inspection, we found that this had not been addressed. This meant that there was still a risk that any discrepencies in stock would not be identified and carrying out effective medicines audits was difficult.

Although the provider told us they carried out medicines audits, they were unable to provide evidence of these.

At our last inspection, we had found that a large number of medicines had passed their expiry date, and a small amount of medicines which were no longer prescribed or used by people who used the service were kept with the currently used medicines. At this inspection, we found that the provider had not addressed this matter. For example, one person's medicine was dated 10 April 2017. We saw that the instructions on the pharmacy label stated 'discard 8 weeks after first opening'. We saw another person's liquid medicine which was dated 18 August 2016 and was half full. Liquid medicines expire at certain timescales after opening, so there was a risk that people using the service might have been receiving medicines that had expired. We were told that these medicines were not being used and we saw that there was a supply of up to date medicines. However, as these were in the same cabinet, we could not be sure that people were not being given medicines that had passed their expiry date.

We also observed that another person's two liquid medicineswere dated 19 August 2016 and were opened and half used. These were kept in the medicines fridge. These medicines' containers stated that when unopened, these can until 2020 before being used. However, because the provider did not record the date of opening on any of the used medicines, we could not be sure that these medicines were safe to use.

The MAR charts for all the people who used the service were signed by staff following administration. However, we saw that there were two signatures missing for one person's medicine, and no code had been recorded to indicate the reason for this. We discussed this with the provider who could not provide an explanation for this. We checked the amount of tablets in the box against the signatures and found that there were three tablets over. In addition, we found one loose tablet in the box, and one unidenfiable capsule. We discussed this with the provider, who was unable to provide an explanation for this.

We saw that there were no staff signatures for two medicines for the period of time between 22 May 2017

and 18 June 2017 for another person to confirm the medicines had been administered. We raised this with the provider who told us that these medicines had been discontinued. However, nothing had been recorded on the MAR charts to indicate this. The senior care worker told us that the GP had communicated this with the pharmacy but this had not been changed by them.

We saw that three other medicines prescribed to be taken daily on the MAR charts for two people had either not been signed for the whole month of June or had been signed on a few occasions. We discussed this with the provider who told us that these medicines were to be given as required (PRN). However there was no record of this instruction on the people's MAR charts and we could not be sure if people were receiving their medicines as prescribed.

The provider had a policy and procedures for the administration of medicines, however there was no protocol for PRN medicines. The staff had attended training in the administration of medicines, but this had not been refreshed since June 2015, and August 2015 for one member of staff, and there were no competency assessments

The provider monitored the fridge and room temperatures daily. However, on the day of our inspection, we found the room was very hot and there was no ventilation. We raised this with the provider who told us that they always opened the window. However, they did not do this on the day of our inspection, so there was a risk that medicines were not as effective as they should be due to the temperature of the room.

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

The Ealing Clinical Commissioning Group (CCG) had carried out a medicines audit on 6 October 2016, and had found the management of people's medicines good, although they had identified some areas for improvement, such as monitoring the room's temperature, reviewing and dating the medicines policy and purchasing a medicines fridge and a controlled drugs cupboard. We saw that the provider had addressed these areas and had made the necessary improvements.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations 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 The registered person had not made suitable arrangements to ensure that medicines were managed safely. Regulation 12 (2) (b) (g)

The enforcement action we took:

Warning notice