Abbeville RCH Limited

Abbeville Residential Care Home

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 28 January 2015. A breach of legal requirements in relation to the management of people's medicines was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to the breach.

We undertook this unannounced focused inspection on 15 July 2015 to check that the provider had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to this requirement. The area we looked at was under the relevant key questions of; is the service safe? You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Abbeville residential care home on our website at www.cqc.org.uk.

Abbeville Residential Care Home is a service that provides accommodation and care to older people and people living with dementia. It is registered to care for up to 38 people. At the time of this inspection, there were 35 people living at Abbeville.

This service requires a registered manager to be in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. There is a registered manager in place at Abbeville Residential Care Home.

We found that the required improvements had not been made. People were at risk of harm because they had not received their medicines as had been prescribed and medicines were not always stored safely. There was a lack of information to guide staff on how to administer PRN

Summary of findings

(when needed) medicines safely and the staff had not been checked to make sure they were competent to give people their medicines. Also, records in relation to people's medicines were not always accurate.

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

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?

The service was not consistently safe.

People's medicines were not managed safely.

Records relating to people's medicines were not always accurate.

Requires improvement

Abbeville 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 Abbeville Residential Care Home on 15 July 2015. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our 28 January 2015 inspection had been made. The service was inspected against one of the five questions we ask about services: is the service safe? The inspection team consisted of one inspector who specialised in medicines management.

Before the inspection, we reviewed the information we held about the service, this included the provider's action plan that they sent us following our last inspection in January 2015.

On the day we visited the service, we spoke with the senior carer and the registered manager.

We looked at nine people's medicine records and staff training records in relation to medicine management.

Requires improvement

Is the service safe?

Our findings

During our last inspection in January 2015, we found that there had been a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was due to some people's medicines not being stored correctly and people not receiving their medicines as intended by their GP. We also found that there was a lack of information to guide staff on when they should give people PRN (when needed) medicines and that some staff had not received the required training to give people their medicines safely. At this inspection, we found that improvements had not been made.

People were not always being given the correct dose of medicines which placed them at the risk of harm. We found that one person had been given an incorrect dose of Warfarin. A further person had not been given a patch to help control their pain at the correct time. Another person had been prescribed two doses of a cholesterol lowering tablet. This had not been questioned by the service and so we asked the registered manager to immediately contact this person's GP to make sure that this was correct.

There remained a lack of guidance in place to guide staff on how to administer medicines to people that were PRN (when needed). This is important so that staff know under what circumstances they should give people these medicines. We also noted that when such medicines were administered, there were no records indicating why the use of the medicine was justified. Therefore we could not be assured these medicines were being used appropriately and as intended by the person who had prescribed them.

We also found that there was a lack of information about people's personal preferences for how they preferred to have their medicines administered and that there were no charts in place to record the application and removal of medicated skin patches. This is important as placing the patch in the same place can result in a person's skin becoming irritated and sore.

Some medicines were not being stored safely. External medicines such as creams were in people's rooms. This placed people who lacked the capacity to understand the potential dangers of these medicines at risk. We found that medicines that required cold storage were being stored in a refrigerator and the temperatures of the refrigerator were monitored and recorded. However, although people's medicines had been moved to a new air-conditioned room since our last inspection, the room temperatures still regularly exceeded the upper temperature range for the storage of medicines. The service was therefore not able to demonstrate that these medicines were being stored appropriately and that they would still be effective and safe when used.

We also noted that medicines that require extra checks and special storage arrangements because of their potential for misuse were being stored in a cabinet that did not comply with Misuse of Drugs Regulations. This was despite this being identified at the last inspection and a new cabinet having been sought.

The manager confirmed that all staff authorised to handle and administer people's medicines had recently received training. However, some had not yet been assessed as competent since the training. Therefore, we could not be sure that all staff who were giving people their medicines were competent to do so.

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

A number of records we checked in relation to the management of people's medicines were either inaccurate or were not being kept. For example, we found a number of discrepancies when checking people's medicine records against the remaining medicines they had left to take. Some records indicated that people had not received enough of their medicines whilst others indicated that they had received too much. It had not been recorded whether people's medicinal creams had been applied as required by the person who had prescribed them. This meant that the records did not accurately reflect what medicines people had been given.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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 The risks in relation to people's medicines were not being managed safely. Regulation 12 (1) and (2) (b).

The enforcement action we took:
We issued the provider and registered manager with a warning notice. They must meet the requirements of this notice by 7 September 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Some people's medicine records were inaccurate. Regulation 17 (1) and(2) (c).

The enforcement action we took:
We issued the provider and registered manager with a warning notice. They must meet the requirements of this notice by 7 September 2015.