Orchard Care Homes.com (3) Limited

Cleveland Park

Inspection report

Cleveland Park
North Shields
North Tyneside
Tyne and Wear
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Date of inspection visit: 13 August 2015
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Ratings

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

Overall summary

We carried out a previous comprehensive inspection of the service on 5 and 19 November 2014, at which a breach of the legal requirements in force at the time was found. This was because medicines at the home were not always managed safely.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook a focused inspection on 13 August 2015 to check that they had followed their plan and to check or establish confirm whether they now met legal requirements.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Cleveland Park' on our website at www.cqc.org.uk'

Cleveland Park Care Home is registered to provide accommodation for up to 66 people who require nursing or personal care, some of whom are living with dementia. It is a purpose built home near the centre of North Shields. At the time of the inspection there were 51 people living at the home.

There was no registered manager formally in place, although an acting manager has been at the home since the previous 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. We have written to the provider and requested they take action to ensure a manager is formally registered with the Commission in order to prevent enforcement action against them.

Summary of findings

We found that the provider had not followed all aspects of their plan, which they had told us would be completed by April 2015, and legal requirements had not been met. We found an ongoing breach in relation to management of medicines which remained unsafe.

You can see what action we have 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?

Not all aspects of the services were safe.

We found that action had not been taken to improve the safety of the service.

We found the management of medicines at the home remained unsafe. National policy and guidance, legal requirements and the provider's own medicines policy were not being adhered to.

This meant that the provider was not meeting legal requirements. We have taken enforcement action against the provider. We will visit the home again to ensure the provider has taken action to rectify the breaches we identified.

Requires improvement

Cleveland Park

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 checked 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 Cleveland Park Care Home on 13 August 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 5 and 19 November 2014 inspection had been made. The inspector inspected the service against one of the five questions we ask about services: is the service safe? This is because the service was not meeting some legal requirements.

The inspection team consisted of one inspector.

We spoke with two nurses who were working at the home at the time of the inspection, one of who was also the deputy manager. The acting manager was on leave at the time of the inspection.

We observed support being delivered in communal areas including lounges and dining rooms, looked and checked some people's individual accommodation. We reviewed a range of documents and records including; four care records for people who used the service, 17 medicine administration records (MARs), staff training records and the provider's policy documentation.

Requires improvement

Is the service safe?

Our findings

At our last inspection we found the provider was in breach of one regulation concerning the safe management of medicines. At this inspection we found that not all the required improvements had been made and there were continued breaches of the regulation related to medicines management.

We found that some blank medicine administration records (MARs) had been photocopied. Where photocopies had been used certain shaded areas of the forms had copied as black. This meant it was not always possible to see if medicines had been given and signed to say they had been administered. This meant there was a danger medicines may not be given or given twice because administration records were not clear.

Some people at the home were being given their medicines covertly. Covert medicines are given to a person disguised in food or drink, because they may otherwise refuse to take them. The Mental Capacity Act 2005 (MCA) requires proper processes to be followed before people receive their medicines in this way. The provider's own medicine policy stated that the requirements of the MCA should be followed before an agreement to administer covert medicines was reached. We found that the required assessments of people's capacity and best interests decisions had not taken place. This meant MCA requirements had not been fulfilled and the provider's own policy had not been followed.

Some people's MARs did not have front sheets containing up to date photographs. One front sheet had a note which identified that a photograph was missing since 7 July 2015, five weeks prior to the inspection. This meant proper systems were not in place to ensure people could be correctly identified prior to administering medicines.

We found that one person was prescribed a topical skin cream because they were at high risk of sustaining skin damage. However, there were no clear instructions about how and when the cream should be applied and there were gaps in records covering several days, meaning it was not clear that the cream had been applied. The provider's own medicines policy indicated there should be clear instructions on all medicines used at the home.

One person was prescribed the medicine Digoxin, which is used to regulate people's heart rate. We found that proper checks on the person's pulse had not always been undertaken. Staff told us the person's pulse did not need to be monitored daily and could be checked weekly. However, there was no care plan or professional instructions in the person's care records to indicate this was the case. This meant the person's medicine was not always administered safely because proper checks were not in place.

Another person living at the home was prescribed the medicine Warfarin. This medicine effects how the blood clots and needs to be carefully administered and monitored. We found there were no clear instructions regarding when the medicine should be given and records relating to the administration were not maintained effectively.

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

We found that medicines at the home were stored safely and securely. The home had a number of controlled drugs. Controlled drugs are medicines where there are legal requirements about how they are stored, used and checked. We checked the records for these medicines and found they were up to date. In addition, the medicines stored matched the number recorded in the home's controlled medicines record book.

We observed the nursing staff dealing with and administering people's medicines and saw people were given their medicines in an appropriate manner; that they were supported to take them, offered a drink and that nursing staff checked tablets had been fully swallowed before signing for them.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Systems were not in place to ensure there was proper and safe management of medicines. Regulation 12(1)(2)(g)

The enforcement action we took:
A warning notice was issued.