Life Style Care plc

The Grange Care Centre

Inspection report

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Overall summary

We carried out a comprehensive inspection of this service on 25, 26 and 27 November 2014. Breaches of legal requirements were found. We took enforcement action by serving a warning notice on the provider requiring them to become compliant with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, management of medicines, by 19 February 2015.

The provider wrote to us following the inspection to say what they would do to meet legal requirements for the breaches we found.

We undertook this unannounced focused inspection on 20 February 2015 to check that the improvements required for the most significant of the breaches had been made. We looked at the actions taken by the provider in respect of the breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We will follow up the breaches found under other regulations at a later date.

We found the provider had addressed the breach of Regulation 13. Legal requirements for the management of medicines had been met. People were being better protected against the risks associated with the unsafe use and management of medicines. This report only covers our findings in relation to that requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Grange Care Centre on our website at www.cqc.org.uk

The Grange Care Centre provides accommodation for people requiring nursing or personal care for up to 160 people. The service has eight units, each with single en suite bedrooms, dining and sitting rooms and bath and shower facilities. Two units accommodate people with general nursing care needs, one unit accommodates people with personal care and dementia care needs, one unit accommodates people with physical disabilities, one unit accommodates people with end of life nursing care needs, one unit accommodates people with behavioural and nursing needs and two units accommodate people with nursing and dementia care needs. At the time of the inspection there were 107 people using the service.

The service is required to have a registered manager in post, and the registered manager has been at the service since August 2014. 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.

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?

Inadequate 

We found that action had been taken to improve safety. We found the provider had taken action to address the most significant concerns about medicines that had a direct impact on people.

Appropriate arrangements for the safe management of medicines were now in place. Staff administering medicines to people had received medicines re-training. All prescribed medicines were available, and were being administered safely, and as prescribed, apart from one cream. More effective systems were in place to monitor the management of medicines.

We noted that further improvements were needed in some areas, such as the storage of some medicines, and ensuring that medicines records were completed in a timely manner directly after medicines were administered, however these did not have any impact on people as far as we could tell at the time of our visit.

We could not improve the rating for Safe from Inadequate because of other breaches under this question and the need to see consistent good practice with the management of medicines over time. We will check these during our next planned Comprehensive inspection.

The Grange Care Centre

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.

We undertook an unannounced focused inspection of The Grange Care Centre on 20 February 2015. This inspection was done to check that improvements to meet legal requirements in relation to management of medicines had been made. We inspected the service against one element of the five questions we ask about services: is the service safe? This is because the service was not meeting legal requirements in respect of management of medicines.

The inspection was undertaken by one inspector. During our inspection we spoke with the improvement director, the registered manager and four nurses. We viewed 62 medicine administration records and 26 care plans for medicine administration.

Inadequate

Is the service safe?

Our findings

At our previous inspection on 25, 26 and 27 November 2015 we found medicines were not being managed safely at the service. People were not always receiving their medicines as prescribed. There were gaps noted in the medicine administration records and correction fluid had been used on one record. Medicine stocks of five medicines for five people had run out and this meant they had missed doses of their medicines. For one person there was a risk they were receiving an as required sedating medicine excessively or inappropriately. Several care plans for medicines were out of date which could have placed people at risk of receiving their medicines incorrectly. Allergies had not always been recorded, placing people at risk of receiving medicines they were allergic to.

At this inspection, we looked at the actions taken by the provider in respect of the breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, management of medicines. We found that the provider had addressed this breach.

We checked the service's arrangements for the management of people's medicines. We found that improvements had been made. The ordering system for medicines had improved. All prescribed medicines were available on the day we inspected. One medicine had been out of stock for two days in February 2015, however the provider was able to provide evidence that this was due to a pharmacy supply issue and not a problem with the home's ordering system.

The system for recording when medicines were administered to people had improved, as medicines records were clear and up to date. Staff checked medicines records at each handover to see if medicines had been given as prescribed, and made a record of this check on an "End of Shift Handover of Medication" record. We did note from these records that there had been some omissions on medicines records prior to our inspection on 20 February 2015, where staff had administered medicines but had forgotten to sign the medicines record directly afterwards, however no gaps were identified on the day of our inspection. When people had allergies, this was clearly recorded for their safety. Better arrangements were in place for the use of topical medicines, such as creams. Care staff had been provided with a "Topical Medicines Application Record", giving details of where and how often to apply these topical medicines. We saw that these records were being completed, providing evidence that these medicines were used as prescribed. We noted on one unit that care staff did not always remember to sign these records when they applied creams, so some improvements where needed to the records for topical medicines.

Authorisations were in place to administer medicines covertly when people did not have capacity and were refusing to take their essential medicines. When people's medicines were changed, clear records were made of the reasons why. Protocols were in place to give staff sufficient information to administer "when required" medicines. We saw that daily stock checks of medicines had been implemented, as a check that medicines were being administered correctly. We looked at the records of these checks, and we checked a sample of medicines administration records against medicines stock and there were no discrepancies, providing assurance that medicines were being administered as prescribed. All of this evidence gave us assurance that medicines were being administered to people as prescribed.

We saw that although sedating medicines were still being prescribed for people with behavioural symptoms of dementia, there was input from mental health professionals, and these medicines were no longer being used excessively. Protocols were available for these medicines, which listed other non-drug interventions to be used before administering these medicines. Staff made a note of the reasons when they had to administer a dose. So we saw that people's behaviour was not being controlled by the excessive or inappropriate use of sedating medicines.

Although most medicines were stored securely, improvements were needed to the storage of topical medicines, such as creams, as some of these were not stored separately from internal medicines. The provider told us that this was addressed following our inspection. Medicines rooms and medicines fridge temperatures were checked and recorded daily and records of these checks showed that medicines were stored at the correct temperatures to remain suitable for use. Controlled drugs were stored securely according to legal requirements, and regular stock checks were carried out to ensure safe and

Inadequate

Is the service safe?

correct use. There was a system in place to deal with drug alerts and medicines safety information. Safe arrangements were in place to dispose of unwanted medicines.

Staff administering medicines had received medicines re-training, and the provider was in the process of completing medicines competency assessments for staff. We saw that when any incidents with medicines had occurred, that incident forms were completed and appropriate action was taken, such as stopping a member of staff from administering medicines until they had received re-training and been reassessed as competent. This meant that arrangements were now in place to equip staff with the skills to manage medicines safely.

We saw that the provider was carrying out regular medicines audits. We looked at copies of these audit reports and saw that they were more thorough, and were more effective in picking up issues with how medicines were being managed compared to when we inspected in November 2014. We saw that the provider had sought advice from the Clinical Commission Group (CCG) medicines management team, and following our inspection, a pharmacist from this team visited the service on 02 March 2015, and noted significant improvements. The CCG pharmacist wrote to us saying that they would be providing more regular support to the service in the future. Therefore there were now internal and external systems in place to monitor the management of medicines.

Overall, we saw that systems for the management of medicines were now more effective, and better protected people against the risks associated with the unsafe use and management of medicines that we noted at our last inspection.