Total Care Home Limited

# Phoenix House Care Home

**Inspection report**

54 Andrews Lane
Formby
Merseyside
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## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|
| Is the service safe? | Requires Improvement |

## Overall summary

At a previous inspection in February 2015, we found that the service was not managing medicines safely. This was a breach of regulations and placed people who used the service at risk of harm. We issued a warning notice to the provider requiring swift action to be taken to ensure that the service became compliant with the regulations. We can issue warning notices to a registered person where the quality of the care they are responsible for falls below what is legally required. We can use them to tell a registered person that they are not compliant with the law. The provider and registered manager sent us an action plan in July 2015 detailing how they would make improvements to meet legal requirements in relation to the breach.

We undertook a focused inspection on 6 August 2015 to check that they had now met legal requirements. At this inspection we found that people were still not fully protected against the risks associated with the unsafe use and management of medicines. People using the service were not protected against the risks associated with the administration, use and management of medicines.

**You can see what action we took at the back of this report.**

This report only covers our findings in relation to this specific area/breach of regulation in respect of the Safe domain. The domains Effective, Caring, Responsive and Well Led were not inspected at this time. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Phoenix House Care Home' on our website at www.cqc.org.uk.

Phoenix House is located in a residential area of Formby. The home provides accommodation and support for up to 30 people. There is disabled access and car parking. Communal areas include lounges, dining room and enclosed back garden. The home is owned by Total Care Homes Limited and there is a registered manager in post. 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 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?**

The service was not safe.

People using the service were not protected against the risks associated with the administration, use and management of medicines. People did not always receive their oral medicines correctly or in a safe way.

**Requires Improvement**

# Phoenix House 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook this focused inspection on 6 August 2015. The inspection was completed to check that improvements to meet legal requirement identified at the comprehensive inspection in February 2015 and the warning notice which we served.

We inspected the service against one of the five questions we ask about the service; Is the service safe? This is because the service was not meeting legal requirements in relation to this question.

The inspection was undertaken by and adult social inspector and a Care Quality Commission (CQC) pharmacy inspector.

Before our inspection we reviewed the information we held about the service and reviewed the provider's action plan, which aims to set out the action they would take to meet legal requirements. At the visit we spoke with the manager and the provider. We looked at medicine administration records (MARs), medicine documents and staff training.

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# Is the service safe?

## Our findings

At a previous inspection in February 2015, we found that the service was not managing medicines safely. This was a breach of regulations and placed people who used the service at risk of harm.

On this inspection we checked to make sure the requirement had been met. We found that people were still not fully protected against the risks associated with the unsafe use and management of medicines.

We looked at medicines, Medication Administration Records (MARs) and other records for seven people living in the home and found concerns and/or discrepancies in four of these cases.

We looked at records for two people who were given their medicines covertly i.e. hidden in food or drinks without the person's knowledge or consent. In the action plan sent to us in July 2015, the provider told us that arrangements for giving medicines in this way would be reviewed and documentation put into place in accordance with the Mental Capacity Act (2005) and current national pharmaceutical guidance, together with detailed instructions for care workers to follow. However, we found that that these arrangements had still not been made. Although some advice had been sought from a pharmacist regarding the safety of crushing tablets and/or mixing them with food and drink, the information received did not mention all the medicines involved, and in some cases, the advice received had not been followed. The information in the care plans was vague and did not describe exactly how or when care workers should offer medicines covertly. It was impossible to see from records which medicines had been given covertly and which had been given with the person's knowledge and consent. The Mental Capacity Act (2005) is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances.

At our previous visit we observed a care worker signing MARs to indicate that medicines had been taken before they were actually offered. This is unsafe practice and is contrary to current national pharmaceutical guidelines. The action plan sent to us assured that all care workers would receive further training and competency tests to ensure that this type of poor practice did not happen again. At this visit we saw one person's MARs being signed before the person had been offered their medicines. The manager told us that no further medicine training had been completed since the warning notice was issued. There was still no formal system in place to assess the competence of care workers to administer and record medicines safely. This placed the health and wellbeing of people living in the home at risk of harm.

When we checked the stocks of medicines against the corresponding records we found that three people had more stock remaining than there should have been. This meant that they had not been given their medicines correctly. Two people had not been given their warfarin tablets (warfarin is a potent medicine that can have serious side effects if not administered correctly), whilst a third person had missed 4-5 doses of two of their medicines even though the MARs had been signed to indicate they had been given. Failing to administer medicines as prescribed and maintain accurate records places the health and wellbeing of people living in the home at unnecessary risk of harm.

Although most MARs were supplied pre-printed from the pharmacy, some MARs had been hand written by care workers. As at our previous visit, we saw that these hand written MARs were incomplete, inaccurate and did not record the full details of either the person or the medicines. The action plan sent to us stated that care workers would receive further training in completing MARs by hand and that all hand written MARs would be checked and double signed by two members of staff. However, the examples we saw had not been double signed by two members of staff and the manager told us that no further training had been carried out.

At our previous visit we had concerns that there was no robust system in place for auditing (checking) the way that medication was managed by the service. The action plan stated that a new system of audit would be put into place. We asked the provider to show us examples of recent audits that had been carried out. The audits we were shown were very brief with no detail of what was actually checked. We could see no evidence that stock had been reconciled with records in order to check that medicines had been given correctly. Furthermore, none of the discrepancies that we found had been noticed by the member of the senior management team who had

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# Is the service safe?

undertaken the medicines round that morning. This was of particular concern as this person was named as responsible for ensuring that many of the changes stated in the action plan were put into place and maintained.

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

We will review our rating for 'Safe' at the next comprehensive inspection.

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<br><br>People using the service were not protected against the risks associated with the administration, use and management of medicines.<br><br>Regulation 12 (1)(2)(g) |

**The enforcement action we took:**
We imposed a condition on the provider which said: " The Registered Provider must not admit any service users to Phoenix House Care Home without the prior written agreement of the Commission and until such time as the Commission is satisfied that your organisation is meeting the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.