# Langley Court Rest Home Limited

# Langley Court Rest Home

**Inspection report**

9 Langley Avenue
Surbiton
Surrey
KT6 6QH
Tel: 020 8399 6766

Date of inspection visit: 04/08/2015
Date of publication: 16/09/2015

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires improvement |
| Is the service safe? | Requires improvement |
| Is the service well-led? | Requires improvement |

## Overall summary

This inspection took place on 4 August 2015 and was unannounced. At the last inspection on 20 April 2015 we found the provider was continuing to breach the regulation in relation to medicines management and we served a warning notice in relation to this.

We carried out this focused inspection to check whether the provider had complied with the warning notice. This report only covers our findings in relation to this requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Langley Court Rest Home on our website at www.cqc.org.uk.

Langley Court Rest Home provides accommodation and personal care for up to 28 older people, many of whom live with dementia. On the day of our visit there were 19 people living in the home.

The home had a registered manager. 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.

At this inspection we found the provider had made the necessary improvements to meet the requirements of the warning notice. However, we identified some areas where best practice in relation to medicines management was not being followed in relation to medicines storage and having guidance in place for staff to follow in relation to topical medicines such as creams, ointments and medicines which were prescribed as required. You can see the action we told the provider to take at the back of the full version of this report.

Although auditing systems in relation to medicines management had improved, they had not identified the issues we found.

# 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?**

**Requires improvement**

The service was not always safe. Although the service had made the improvements required in the warning notice we found further areas where best practice guidance in relation to the management of medicines was not being followed. These were in relation to medicines storage, risk assessments for a person who recently began self-administering, and guidance for staff to follow in administering creams and as required medicines.

Arrangements to ensure staff administering medicines focused on the task and not be distracted were in place. Our checks of medicines did not find any discrepancies which indicated people received their medicines as prescribed.

We could not improve the rating for 'Is the service safe' from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

**Is the service well-led?**

**Requires improvement**

The service was not always well-led. Although the home had made some improvements to their systems in auditing medicines, audits had not identified the issues we found. We did not check other aspects of quality assurance at this inspection but will check these at our next comprehensive inspection of the home.

We could not improve the rating for 'Is the service safe' from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

# Langley Court Rest 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.

This inspection was undertaken to check that the provider had made improvements to meet legal requirements after our 20 April 2015 inspection. We inspected the service against two of the five questions we ask about services: Is the service safe? Is the service well-led? This is because the service was not meeting some legal requirements previously and required improvements in other areas.

This inspection took place on 4 August 2015 and was unannounced. It was undertaken by a pharmacy inspector.

Before our inspection we reviewed information we held about the service such as the previous inspection report.

During the inspection we spoke with the deputy manager, a senior care worker and four people using the service. We looked at medicines records for 19 people as well as medicines audits.

Requires improvement

# Is the service safe?

## Our findings

At the last inspection in April 2015, we found a breach of the regulation in relation to medicines management. Medicines management was unsafe because we could not always confirm medicines were given to people as records indicated. In addition, staff who administered medicines were not always able to focus on this task to reduce the likelihood of mistakes and did other tasks such as dealing with visitors. During our last inspection, this contributed to medicines being administered more than three hours late to people. We took enforcement action by serving a warning notice for a breach of the regulation in relation to medicines, requiring the provider to make improvements by 07 July 2015.

During this inspection we noted that although staff had received medicines re-training, we identified some areas where they were not following current medicines good practice and national guidance, to make sure the management of medicines was as safe as possible. For example, risk assessments for a person who recently began self-administering medicines in the home were not in place. This meant we could not be sure they were administering these safely. Temperature monitoring of the medicines storage area was not taking place. This meant that medicines might not have been stored at the correct temperatures. Protocols for staff to follow when administering when required (PRN) medicines and applying prescribed topical medicines, including creams and ointments were not always in place. This meant staff may not have had sufficient guidance on when these should be used, and people may have been at risk of receiving these medicines inconsistently. The provider wrote to us following the inspection, on 10 August 2015, to confirm they had taken immediate action, and were making all of the necessary changes to manage medicines according to current good practice. However, we were not able to check whether all the improvements have been made as required and we were not assured that the provider had the arrangements to make sure medicines were consistently being managed safely.

A new medicines trolley had been obtained, and medicines were stored securely, however a controlled drug had been prescribed for one person in July 2015, which was not being stored according to best practice guidance in a separate controlled drugs cabinet. The deputy manager placed an order for a suitable controlled drugs cabinet after the inspection. In addition they ordered a medicines refrigerator for storage of insulin and other medicines requiring refrigeration, as these were currently being stored in the domestic food fridge and there was no risk assessment with a management plan in place regarding this.

The deputy manager told us that staff had received medicines refresher training. We saw evidence that staff responsible for administering medicines to people had signed a document to confirm that they had read the medicines policy, and that they understood how to manage medicines safely. At the last inspection, the director told us that he planned to introduce competency assessments for staff to check they were able to administer medicines to people safely, however these assessments had not yet been implemented but were in development.

Whilst the concerns we identified in the warning notice we served on the provider have been met, we have sufficient evidence to show that medicines were not being managed as safely as possible and the provider was still in breach of regulation 12 of the Health and Social care act 2008 (Regulated Activity) Regulations 2014.

Medicines profiles had been written for some people, listing their current medicines, what these were for, and potential side effects. The deputy manager told us these profiles were going to be written for all people who used the service. Medicines information leaflets were available for all prescribed medicines, so that staff and people at the home had access to information about their medicines. When we spoke with the member of staff administering medicines on the day of the inspection, they were able to explain what the medicines they were administering were for. The staff member was also wearing a tabard to identify that they were administering medicines and should not be disturbed, so that people would receive their medicines safely and on time. On the day of the inspection we saw that medicines were administered at the correct time, and that the member of staff was not undertaking any other tasks during the medicines round.

The times that medicines were due had been colour-coded on people's medicines charts to match the colours of the blister packs, for example the evening blister packs were blue, and so the evening doses were highlighted in blue on medicines charts, to reduce the risk of medicines errors.

Requires improvement

# Is the service safe?

When we checked medicines administration records and medicines supplies, there were no gaps in recording, or stock discrepancies, indicating that people had been given their medicines regularly and correctly. One person was prescribed an anticoagulant medicine, and we saw that this was managed safely.

Requires improvement

# Is the service well-led?

## Our findings

At the last inspection we found the service was not always well led. Medicines audits had not identified the issues we found in relation to medicines management. At this inspection we found that that the provider had made improvements. Checks of medicines supplies were now carried out more frequently, to identify errors or omissions, and we saw from the audit logs there had been no medicines errors. However, auditing systems had still not identified the issues we found at this inspection relating to medicines management.

At the last inspection we also identified the provider did not record audits of care plans they carried out and they told us they would begin to record these. In addition, the director told us they were considering introducing an enhanced quality auditing system where a suitably competent person would check all aspects of service provision on a regular basis. However, because this inspection was focused on the warning notice in relation to medicines we did not inspect other auditing systems in the home besides those for medicines. We will check other auditing systems, as well as other aspects of the leadership of the service, at the next comprehensive inspection of this service.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The registered person did not ensure the proper and safe management of medicines in ensuring care and treatment was provided in a safe way for people.<br><br>Regulation 12(1)(2)(g) |