Greenacres Care Home Limited

Greenacres Care Home

Inspection report

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Ratings

Is the service safe?	Inadequate

Overall summary

We carried out an unannounced inspection of this home on 10 March 2015. Breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were found. After the comprehensive inspection we served a warning notice on the registered provider and registered manager of the home requiring them to be compliant with the Regulation by 30 May 2015.

We undertook this focused inspection on the 27 July 2015 to check they had met the legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Greenacres Care Home on our website at www.cqc.org.uk.

A registered manager was in not place. Following our previous inspection the registered manager has ceased to work at the home and had deregistered with the Care Quality Commission. A new manager was in place and they had applied to register with us. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

The home is located in the village of Heckington in Lincolnshire. Accommodation is all on one level and the home is registered to provide care for 28 people whose may be living with dementia, a mental health condition, a physical disability or need residential care due to old age.

The provider had made improvements to the safety of the home by reviewing and updating their systems in relation to medicines. Medicines were safely stored, disposed and administered. Audits and reviews of incidents ensured medicine issues were identified and corrected. Records related to medicine administration were complete.

This meant that the registered person was now meeting legal requirements.

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 always safe.

We found that action had been taken to improve safety. Medicines were administered safely. Audits and incident reporting ensured good systems were in place to support the ordering, storing and disposing of medicines safely.

This meant that the registered person was now meeting legal requirements.

We could not improve the rating for safe from inadequate as we only reviewed how the home manages people's medicines. Improvements in other areas of this key question will be reviewed at our next inspection.

Inadequate

Greenacres 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 Greenacres Care Home on 27 July 2015. This inspection was completed to check that improvements to meet legal requirements had been completed by the registered manager and provider after our comprehensive inspection of the home on 10 March 2015. The home was inspected against one of the five questions we ask about services: Is the service safe. This was because the home was not meeting some legal requirements.

The inspection was completed by a single inspector. Before our inspection we reviewed the information we held about the home, including previous inspection reports. We reviewed notifications of incidents the manager had sent to us since the last inspection. A notification is information about important events which the home is required to send us by law.

We observed care and support being delivered by staff in relation to administering medicine. We spoke with the manager, assistant manager and a senior carer. We looked at the care plans and the medicine records for all of the people who lived at the home. We looked at records relating to the management medicines in the home.

Inadequate

Is the service safe?

Our findings

At the inspection on 10 March 2015 we found that medicines were not managed safely. We saw the registered manager did not follow safe practice when administering people's medicines. The registered manager did not follow appropriate infection control processes when administering medicines. The medicine administration record (MAR) charts were not presented in a way which supported safe administration of medicines. There were multiple gaps in the MAR charts so we could not be sure if people were given their medicine appropriately. The registered manager made clinical decisions around medicines. There was also no guidance in people's care plans to help staff administer medicines prescribed to be taken as required effectively.

At our inspection on 27 July 2015 we found action had been taken to improve the safety of managing medicines. Medicines were now stored in an appropriate environment and in line with legislation.

The manager told us and records showed that all staff who administered medicines had completed additional training in medicines. The manager told us they had completed competency checks on all staff who administered medicine and records confirmed these had been done. Where the manager had identified issues with competency these had been followed up with the staff member involved. For example, one care worker had been advised to use a spoon to administer medicines if people could not put them in their mouths themselves.

We observed a senior care worker complete a medicines round. We saw they worked in a systematic way and administered medicines to people safely and in a way which reduced the risk of errors. We saw they offered people the medicine which had been prescribed to be taken as required. However, the senior care worker was not always clear what the medicine was for so was unable to give this information to people to help them make an informed decision.

Medicine administration records were better organised with dividers between people's records and photographs for identification. Records had been accurately completed with no gaps. Some care plans had been reviewed and these contained information to support the safe and person centred administration of medicine. There were plans in place to review all care plans and update the information regarding medicines. Where a person continually refused their medicine staff had discussed their concerns with the doctor.

The manager had completed monthly audits around medicine ordering, storage and administration. We saw any concerns identified were dealt with and discussed with staff at team meetings. Incident reporting was in place and recorded actions to be taken to stop the incident reoccurring in the future.