

People in Care Ltd

Church View Residential Home

Inspection report

Church Street
Oswaldtwistle
Lancashire
BB5 3QA

Tel: 01254381652

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18 April 2016

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Summary of findings

Overall summary

We undertook a focused inspection on 26 April 2016. The inspection was unannounced which meant they did not know we were coming.

Church View Residential Home is registered to provide care for up to 30 older people. The home was providing care for older people which included people living with a dementia; the home does not provide nursing care. At the time of the inspection there were 22 people in receipt of care.

The registration requirements for the provider stated the home should have a registered manager in place. The registered manager had recently left employment with the service and a new home manager was in post. The home manager told us they intended to commence the application process for registered managers with the Commission. 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 the last inspection on 18 September 2015 we asked the provider to take action to make improvements in the way medicines taken by mouth were administered and recorded. The home now carried out monthly audits. Any discrepancies, which may indicate that a person had not received all their doses of medicine, were investigated.

We watched some people being given their morning medicines and saw the senior carer gave medicines in a kind and safe way. Medication charts examined were completed in full and there were no discrepancies in the stock checks.

Medication creams were not being used safely and staff did not have access to information they required to administer these. The disposal of unwanted medicines that are controlled drugs was not recorded and witnessed in the way required by law.

People using the service and visitors told us they felt safe in the home. One person told us, "Nothing is worrying me, I feel safe."

We saw evidence of appropriate procedures taken when dealing with allegations of abuse. Staff had access to the safeguarding and the whistleblowing (reporting bad practice) policy and procedure to guide them.

We looked at the care files for people currently in receipt of care. We saw improvements had been made. There was some evidence of care plans and risk assessment to guide staff on how to meet people's individual need such as, personal care, behaviour monitoring and medication. There was some evidence of reviews taking place however not all had been updated recently.

Staff had access to policies to guide them on assessment and care plan as well as resident daily records and control of quality records.

During this inspection we identified breaches of regulation in relation to the management of medicines and records.

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 consistently safe.

People using the service and visitors told us they felt safe in the home.

We saw evidence of appropriate procedures taken when dealing with allegations of abuse.

We watched some people being given their morning medicines and saw the senior carer gave medicines in a kind and safe way, however we found some aspects of medication administration that was not safe.

Medication creams were not being used safely and staff did not have access to information they required to administer. There was a lack of information for staff on why some medicines had been prescribed and how they should be used.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

We looked at the care files for people currently in receipt of care. We saw improvements had been made however, there were gaps in recording and reviews of care files were required.

Staff had access to policies to guide them on assessment and care plan as well as resident daily records and control of quality records.

Requires Improvement ●

Church View Residential 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 took place on 26 April 2016. The inspection was unannounced. This meant the provider did not know we were coming. The inspection was undertaken by one adult social care inspector and one pharmacy inspector.

This inspection was a focused follow up inspection to check the actions taken as a result of breaches identified at our last inspection. Prior to the inspection we looked at information we held about the service including information received on the actions taken to resolve the concerns identified in the breaches and we spoke with professionals from the Local Authority.

We used a number of different methods to help us understand the experiences of people who used the Service. We spoke with six people currently in receipt of care, two visitors, five staff members, the home manager and two directors.

We looked at a number of records including six care files, policies and procedures, audits and quality checks as well as all the medication administration records for people living in the home. We made some observations.

Is the service safe?

Our findings

At the last inspection on 18 September 2015 we asked the provider to take action to make improvements in the way medicines taken by mouth were administered and recorded. The home now carries out monthly audits to compare stocks of medicines and the records on people's medicine charts. Any discrepancies, which may indicate that a person had not received all their doses of medicine, were investigated.

At this inspection we found that the home continued to be in breach of regulation 12 of the Health and Social Care Act 2008 (RA) Regulations 2014. Prescribed creams were not used safely and staff did not have the information they needed to give some medicines in the right way. The disposal of unwanted medicines that are controlled drugs was not recorded and witnessed in the way required by law.

We watched some people being given their morning medicines and saw the senior staff member gave medicines in a kind and safe way. Medicines due early in the morning were administered by night staff to make sure people got them at the right time. Two senior staff gave one person their regular 'pain relief' tablet without first checking their medicine chart. This is unsafe practice as there is a greater chance of a mistake being made. Following our inspection the home manager confirmed all staff had undertaken medication training updates and had received competency checks.

We looked at the medicine charts of all 22 people living in the home and did not see any 'gaps' in the records of administration. The amount of medicine in stock on the day the chart started was recorded so medicines could be accounted for. We checked the stock of two people's tablets against the chart records and found no discrepancies. This indicated that the records were accurate and people were given their oral medicines in the right way. Staff signed a different chart when they applied a person's prescribed emollient cream. We saw that 18 people were prescribed creams and five of these 18 people needed the cream regularly, rather than just 'when required'. There were very few signatures on any of the 18 charts to show that creams were being applied and people's skin was cared for properly.

There was a lack of information for staff on why some medicines (creams and 'when required' tablets) had been prescribed and how they should be used. Staff were applying one person's strong, medicated cream without understanding its action and side effects. Another person's steroid cream was being applied the wrong number of times a day by senior carers. If medicines are not administered in the right way this puts people at risk of harm.

The home audited the use of medicines, but audits did not include people's prescribed creams. Medicines were stored securely and at the right temperatures. However, the medicine refrigerator was not monitored properly as maximum and minimum fridge temperatures were not recorded. Medicines that are controlled drugs were stored in the way required by law and staff checked stocks regularly. The disposal of unwanted controlled drugs was not recorded and witnessed properly. If controlled drugs are not managed in the right way there is a risk of misuse.

During our inspection all people we spoke with told us they felt safe in the home, one person told us, "The

staff are lovely I feel safe" another said, "Nothing worrying me I feel safe."

During our tour of the building we observed advice on display to guide people on the procedure to take if abuse was suspected and we saw there was a safeguarding and whistleblowing (Reporting bad practice) policy and procedure available for staff to follow along with advice in a staff safeguarding handbook. This would ensure people who used the service were protected from the risks of abuse because staff had the required guidance to follow in the event of an allegation.

Prior to our inspection we had been made aware of a concern that had been raised relating to the care of one person. We discussed these concerns with the home manager who was able to discuss the details of the allegations and the appropriate actions taken as well as outcomes from their investigation.

We looked at the safeguarding file; systems were in place to ensure people using services were protected from the risk of abuse. This was because there was evidence of a running log which detailed dates of allegations, referrals to appropriate authorities as well as notifications made to the Care Quality Commission. This would aide an effective audit trail of investigations. Copies of templates were seen as well as completed referral forms with records relating to investigations.

Is the service responsive?

Our findings

At the last inspection on 18 September 2015 we identified concerns relating to records for people living in the home. The provider failed to ensure records relating to people's individual care needs were complete and up to date. This was a breach of Regulation 17 of the Health and Social Care Act (RA) Regulations 2014. We asked them to send us an action plan on the changes they would make to ensure people received care safely.

People told us they were happy with care received, one person said, "I have no concerns the care is good" and, "The care is good they discuss care with me." A relative told us the care was discussed with them and they were kept up to date with any changes.

We looked at the care files for people currently in receipt of care. We saw improvements had been made. Records included personal information such as date of birth, GP, next of kin and any known allergies. Preadmission Assessments were in place and provided sufficient information to determine if people's needs could be met and to plan for their admission.

There was some evidence of care plans and risk assessment in peoples care files to guide staff on how to meet people's individual need such as, personal care, behaviour monitoring and medication. This would aide staff in delivering appropriate care. There was also some evidence of reviews taking place, however not all had been updated recently and one person's care file we looked at we saw sections that had not been completed in full.

The home manager told us that some of the care plans still required review and updating. They told us, "There are not many care plans outstanding to be reviewed." A staff member we spoke with told us, "Things aren't moving forward. I hold my hands up not all the care plans are done but we are working through them." The home manager gave assurances that all care files would be reviewed and they confirmed to us these reviews had taken place following our inspection.

There was a file that contained completed records which included bathing, positional changes as well as staff handover sheets. There was a separate file which contained completed daily records which included notes on personal care, diet and fluid intake, visitors and professional reviews. This would ensure staff had access to up to date information about people using services.

Staff had access to policies to guide them on assessment and care planning as well as resident daily records and control of quality records.

Evidence of audits on care files were taking place and included a summary of findings as well as actions to be taken as a result of the audit. This would ensure gaps in care files was identified and acted upon. However one care file had evidence of an audit form in it that was blank.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulations) 2014 good

governance.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 The provider had failed to have suitable arrangements in place for the proper and safe management of medicines. Regulation 12. – (2)(g)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure records were maintained complete and contemporaneous. Regulation 17. – (1) (c)