Lifestyle Care Management Ltd

Eltandia Hall Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 29 March 2017 and 6 April 2017 and was unannounced. At our comprehensive inspection in December 2015 we found breaches of regulations in relation to safe care and treatment, staff support and good governance. We carried out a focused inspection in April 2016 to check whether these breaches had been met. We judged that the service had made improvements and was meeting these breaches of regulations. However, at our last comprehensive inspection in December 2016 we found breaches of the same regulations as at our December 2015 inspection with further breaches of regulations relating to receiving and acting on complaints and the need for consent. We issued warning notices to the provider in relation to the breaches of safe care and treatment and good governance and requirement notices for the other breaches. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches by 13 February 2017.

We undertook this focused inspection to check the provider had followed their action plan and to confirm that they now met the requirements of the warning notices. We will check the provider's improvements in relation to the other breaches of regulations at a future inspection. We found the provider had improved their medicines administration processes overall. However, we identified one medicines error which resulted in a person not being administered a medicine as prescribed. It was a similar error to one we had identified at our previous inspection and meant the person was not being treated appropriately for their health condition.. This meant the provider was still breaching the regulation relating to safe care and treatment, although they had made many of the improvements we had asked them to make in the warning notice. You can see what action we had asked the provider to take at the back of this report.

Eltandia Hall Care Centre provides care and support for up to 83 people and at the time of our visit 73 people were using the service. It has two units on the first floor for people who need personal care and two units offering nursing care on the ground floor. Three of the units provide care for older people and one unit provides nursing care for younger adults with physical disabilities. The service has a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

Medicines management was not always safe. Our checks indicated people did not always receive their medicines as prescribed. When we raised our concerns with the provider they carried out a thorough investigation and initiated proceedings to prevent this from occurring again. Other medicines practices had improved. Medicines were stored securely and medicines stocks were well managed. 'As required' (PRN) medicines and 'homely remedies' (medicines which can be purchased over the counter) were administered safely following clear protocols. Staff who administered medicines received suitable training and assessment of their competency to ensure they were suitable to manage medicines in the service.

The registered manager had reduced the risks to people which can arise from the use of bed rails. Risk assessments of the use of bed rails had been carried out with risk management plans in place for staff to follow as part of keeping people safe. Where risk assessments identified people were at risk of entrapment

or from falling out of bed due to inappropriate use of bed rails the registered manager had taken action to reduce these risks.

The provider had reviewed systems to assess, monitor and improve the service, including introducing a new system of medicines audits. However this new system had not identified the medicines error we identified. Systems to monitor staff supervision, complaints and issues relating to consent had been improved. Records relating to people's care plans and monthly evaluations of people's support needs were more comprehensive and consistent. In addition staff were using and recording findings from a tool to screen people's risk of malnutrition correctly.

Records relating to accidents and injuries and water temperatures across the home had also improved and were now well maintained. We found that records relating to wound management were lacking on the day of the inspection. However the registered manager addressed this immediately and evidenced they had implemented frequent recording of wound evaluations in order to track and monitor progression of people's wounds.

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

We found the provider had not taken sufficient action to improve the management of medicines. Our checks showed that the arrangements in place to ensure all people received their medicines as prescribed, were not very effective.

Medicines were stored, administered and recorded appropriately. Stocks of medicines were well controlled. Staff received the necessary training in order to manage people's medicines safely. Risk relating to bed rails were managed well so people were better protected from risks.

Is the service well-led?

Requires Improvement

We found the provider had improved their quality assurance systems and records to help protect people against the risks of unsafe and inappropriate care. However, the systems had not identified the medicines error we found. In addition, records relating to wound management required improvement. The registered manager addressed this immediately and evidenced they had initiated frequent recording of wound evaluations in order to track and monitor progression of people's wounds.

Eltandia Hall 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, 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 29 March 2017 and 6 April 2017 and was unannounced. It was carried out by one inspector and a pharmacist inspector. This inspection was completed to check that improvements to meet legal requirements planned by the registered provider after our comprehensive inspection on 16 December 2016 had been made. 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 legal requirements in relation to those key questions at that inspection.

Before our inspection, we reviewed the information we held about the service such as statutory notifications relating to allegations of abuse.

During our inspection we spoke with four people, the registered manager, the operations manager, two clinical leads, two nurses and a maintenance operative. We looked at records, which included four people's care plans and risk assessments, medicines records and records relating to the management of the service.

After our inspection we contacted the local authority commissioning team for their feedback on the service.

Requires Improvement

Is the service safe?

Our findings

In our December 2015 inspection we identified a breach of regulation relating to safe care and treatment and more specifically in respect of poor medicines management. At our focused inspection of April 2016 we found the provider had taken sufficient action to meet this breach of regulation. However at our inspection in December 2016 we identified a further breach relating to poor medicines management. In addition we found risks relating to people's bed rails were not always managed safely. We issued a warning notice to the provider in relation to this breach of regulation and asked them to make the necessary improvements by 13 February 2017.

After the inspection the provider wrote to us to inform us of the action they were taking in relation to the breach. Their actions included reviewing staff training and competency assessments as well as practices relating to the management of medicines and also medicines records.

We identified there remained a breach in relation to medicines management. This was because a medicines recording error led to a person not receiving a medicine as prescribed, which meant the person did not receive appropriate treatment for their health condition. We identified a similar issue at our last inspection with the same medicine not being administered as prescribed which indicated the improvements the provider made to medicines administration were not very effective in making sure all people received their medicines as prescribed. These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we identified a breach of regulation relating to medicines management we found the provider had taken action to meet the requirements of the warning notice. We spoke with four people who reported that they received their medicines in a timely manner. They were happy with the way staff handled their medicines. We looked at 14 people's medicines administration records (MAR) and found no gaps in the recording of medicines administered, including for topical medicines such as creams. Where a variable dose of a medicine was prescribed (e.g. one or two paracetamol tablets), we saw a record of the actual number of dose units administered to the person. This indicated people received their medicines as prescribed. People's allergies were noted on their MAR which reduced the risk of people receiving medicines they were allergic to.

Medicines were administered by nurses that had recently been trained in medicines administration. We observed a member of staff giving medicines to a person and saw they did this in a caring manner. Staff recorded their signatures after administration. We also observed staff administering insulin after taking blood glucose levels, a practice which had improved since our last inspection. Staff wore high visibility vests which indicated they were administering medicines and should not be disturbed to reduce the risk of errors happening.

We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. Records showed people's behaviour was not controlled by excessive or inappropriate use of medicines. For example, we saw PRN forms for pain-relief and laxative medicines. There were appropriate

protocols in place which covered the reasons staff should administer the medicine, how they should expect the person to respond after receiving the medicine and what to do if the medicine did not have its intended benefit.

There was a homely remedies protocol in place which covered the use of over the counter medicines such as paracetamol. Running balances of these medicines were kept updated and the provider was in the process of seeking authorisation from their GPs in providing further homely remedies in the future.

The registered manager had reduced the risks to people from the risks associated with the unsafe management of bed rails. They had carried out risk assessments of bed rails and put risk management plans in place for staff to follow in relation to these. Where they identified people were at risk of entrapment in the bed rails or from falling out of bed due to inappropriate use of bed rails they had taken action to reduce these risks.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in December 2016 we found the provider had not sustained improvements in areas of the service where we had previously identified concerns, such as at our December 2015 inspection. We also found new breaches of regulations relating to consent and the management of complaints. We served a warning notice on the provider in relation to the breach of regulation relating to good governance and asked the provider to make the necessary improvements by 13 February 2017.

After the inspection the provider wrote to us to tell us how they would meet the requirements of the warning notice. They told us they would improve auditing processes to identify issues such as those we identified during our inspection, and would also improve the management of records within the service.

The provider had improved systems to assess, monitor and improve the quality of the service. However, although systems to audit medicines had been reviewed, they had not identified the medicines error we found. The clinical lead showed us a detailed action plan in place to ensure the service improved in relation to the breaches we identified at our last inspection, and told us the improvements were on schedule. The improvements included revised audits of care plans and risk assessments, systems to track when staff had received supervision and when their next supervision was due, more efficient recording systems relating to complaints and a revision of how people's consent to care and treatment was sought.

At this inspection we found the provider had improved most recording systems, but people remained at risk from the poor management of wound records. At our last inspection we found staff did not always evaluate and document the condition of people's wounds each time they were dressed or use tracings as recommended by the National Institute of Clinical and Healthcare Excellence (NICE, 2014) to monitor whether the wounds were healing. Written evaluations including descriptions of the wounds were recorded inconsistently. This meant that recording in relation to people's wounds did not enable the close monitoring of wounds. At this inspection we found this had not sufficiently improved. Staff had begun to take photographs of people's wounds but these were not used effectively because they were taken inconsistently and records relating to measurements and descriptions to go alongside the photographs were inconsistently recorded. We found evidence from records of communication between staff and the tissue viability nurse (TVN) that people's wounds were all healing well. However, risks to people from poor wound records remained. The registered manager told us they would immediately address this and they contacted us after the inspection to evidence they had implemented frequent evaluations of wounds with accurate recording systems.

We found records relating to a screening tool to assess people's risk of malnutrition had improved. In addition people's care plans and monthly evaluations of their care now contained consistent information, so when people's care changed their evaluation reflected this. We also found records relating to accident and incidents and hot water temperatures had also improved so the risks of people receiving poor care due to poorly maintained records were reduced.

We found the provider had improved audits relating to medicines management. We saw evidence of several

recent audits carried out by the provider, the Clinical Commissioning Group's (CCG) pharmacist and the community pharmacy supplier. The audits included the safe storage of medicines, checking the medicines room and fridge temperatures and daily checks of medicines stocks to check medicines had been administered as prescribed. The provider had also introduced more robust checks on the disposal of unwanted medicines.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not provide care in a safe way for people by ensuring the proper and safe management of medicines. Regulation 12(1)(2)(g)