Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Abbey Park

Humber Road, Coventry, CV3 4FE

Tel: 02476506045

Date of Inspection: 22 July 2014

Date of Publication: September 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Management of medicines	✖ Action needed
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✖ Action needed

Details about this location

Registered Provider	Methodist Homes
Registered Manager	Mrs Tina Thompson
Overview of the service	Abbey Park is a nursing home offering care for up to 84 people who require specialist nursing, rehabilitation and dementia care. The home provides care in separate units over two floors.
Type of services	Care home service with nursing Rehabilitation services
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Abbey Park had taken action to meet the following essential standards:

- Management of medicines
- Assessing and monitoring the quality of service provision
- Records

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 22 July 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with carers and / or family members, talked with staff and were accompanied by a pharmacist.

What people told us and what we found

During our last inspection visit to Abbey Park on 1 April 2014, we identified improvements were required in three areas, the management of medicines, assessing and monitoring the quality of service and records.

During this inspection we focused most of our time on the Greyfriars and Whitefriars units. This was because we identified these areas as needing improvement during our last inspection. Medicines were also checked within the "Arden" unit.

We found some improvements had been made across all areas but further improvements were needed. This was in relation to medicine management and the completion of records.

We looked at three care plan files and observed how people were being cared for to see if they received person centred care. We saw actions had been taken to seek the views of people who lived at the home and to review care plans to make sure people received more person centred care. We saw systems were in place to monitor the ongoing quality of the service.

We found some of the care records in care plans were not always clear or sufficiently detailed to make sure staff met people's needs safely and appropriately.

Relatives we spoke with were positive in their comments of the home. They told us, "The care has been brilliant. I have no complaints they have all been really helpful." "The care is quite good."

A pharmacist inspector from the Care Quality Commission visited the home to look at

medicine management. We assessed if people's medicines were being managed safely and if arrangements were in place to protect people against the risks associated with the unsafe use and management of medication.

We were told the service had made improvements since our previous inspection on 1 April 2014. This included more checks to ensure people were being given their prescribed medicines. The 'Medicine Management Care Homes Team' from Coventry and Rugby Clinical Commissioning Group had also undertaken a visit to the service on 21 May 2014. We were shown the report which identified some issues that required further action. In particular, that people should "receive their medicines at the correct times" and also "there did not seem to be a system in place to go back to residents who were not in their rooms". We found improvements had been implemented to ensure that people were given their 'time critical' medicines at the correct time. We also found that medicine errors were being more openly identified with lessons learnt and shared with nursing staff.

During our inspection we found one medicine error which had not been dealt with immediately. This meant that although there were overall improvements in safe medicine management, we could not always be assured that people were being given their medicines as intended by prescribers.

Appropriate arrangements were not always being undertaken in order to manage the risks associated with the unsafe use and management of medicines.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 17 September 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Management of medicines	✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider was not ensuring that appropriate arrangements were in place to manage medicines.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at how medicines were stored on three units (Whitefriars, Greyfriars and Arden). We also looked at the medicine administration records for eight people who lived at the home. We recognised improvements had been made since our previous inspection on 1 April 2014. We found that despite increased checks on medicines, appropriate arrangements were still not always being undertaken to manage the risks associated with the unsafe use and management of medicines.

At the time of our arrival 10.35am, the morning medicine round on Whitefriars was underway. We noted that the morning medicine round was lengthy and not completed until just after 11.00am. This was same as at the previous inspection and there were similar findings by the CCG visit in May 2014. We were told the 'time critical' medicines such as people's pain relief were given priority. We saw a document which listed the names of people who required medicines to be given as a priority. Whilst we recognised action had been taken to ensure people were given 'time critical' medicines at the correct time, it is important that people are given all their medicines at the time prescribed.

We were told medicine checks were being undertaken. We were shown copies of the medicine checks which identified any issues to be dealt with by the nursing staff team or management. We were also shown copies of reports of medicine errors. These identified what had happened and what action was taken to prevent them happening again. We acknowledged these improvements which helped to ensure people were safe from harm. During our inspection we identified a medicine error which had not been dealt with immediately or reported to management. One person had been given a medicine which had been stopped by the hospital when they were discharged. On informing the service of our findings the person's GP was contacted and further action was taken to clarify the

person's correct medicines to maintain the person's health and wellbeing. This meant that although there were significant improvements, we could not always be assured that medicines were given to people as intended by the prescriber.

Medicine administration records (MAR's) were completed to document if people had been given their prescribed medicines. In particular we looked at the MAR charts for two people prescribed a medicine that needed to be carefully monitored in order to make sure they were given a safe dose. We found improved arrangements were in place for accurate medicine stock checks. This meant it was possible to check the balance of this particular medicine to ensure it had been given as prescribed. We found the completion of MAR's had improved. Arrangements were in place to ensure hand written MAR charts were accurate. We saw records documented when people had been given their medicines or a record was documented to explain why it had not been given.

Arrangements had improved in making sure people's prescribed medicines were available to give. We were shown the minutes of a meeting between the service, the GP practice and the supplying pharmacy dated 6 May 2014. These showed what improvements and changes were being made to ensure medicines were ordered, obtained and delivered in time. We found people's medicines were available to administer to treat their diagnosed health conditions.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

We observed how people were being cared for on the Greyfriars and Whitefriars units and spoke with relatives about the care and services provided.

Relatives were generally positive in their comments of the home. They told us, "The care has been brilliant. I have no complaints they have all been really helpful." "The care is quite good." "It would be nice if they had time to sit and chat (to people)."

We saw a note on a care file from a relative that stated, "I am very happy with X's care. I … always observe the staff being kind respectful and knowledgeable in caring for X."

During out last inspection to the home on 1 April 2014 when we observed the Greyfriars dementia unit, we found people did not always experience care and support in a person centred way. We noted music was being played and the television was on at the same time in the lounge/dining areas. The music was not age appropriate.

During this visit we found this was no longer the case. The music being played was more age appropriate and the television was not on at the same time.

During our last visit tables were not readily available for people to rest their drinks. We saw during this visit, all people seated in the lounge area had a table available for their drinks.

We saw staff were friendly in their approach towards people. Staff we spoke with were knowledgeable of people's needs and how they should be met.

On the day of our visit it was a sunny and warm day. We saw staff regularly offered and provided drinks to people in the lounge. They also provided people with ice lollies to keep them cool. We saw one member of staff assisting a person to eat one at a pace that was appropriate to them.

The activity organisers at the home asked people in the lounge if they would like to attend

a trip to a park. We saw people were assisted in wheelchairs to the mini bus. Staff provided people with hats to provide protection against the sun.

The provider may find it useful to note we saw two people in their rooms calling out for staff that were not responded to. One person who was confused was tearful because they did not know what to do about a funeral. We heard one person to say, "Anybody about please" several times. They went on to say, "I give up nobody bothers to answer me, I want to go home, anything to get out of here, please." We saw staff were in the dining area completing records. We found it was difficult to hear people calling out in this area when the music was being played. When staff responded to people they did not spend any length of time with them to provide reassurance. We could not be confident that some people were receiving sufficient social stimulation. For example, in one person's records it stated music should be played when they were in bed. When we visited the person in their room, no music was being played.

We saw there were systems in place to enable the provider to obtain the views of people who used the service. This included "resident/relative" meetings and quality monitoring questionnaires. We saw the questionnaires identified issues for action which had been followed up on an individual basis and action points recorded.

We saw records of positive comments made to staff by people's relatives. These included, "Very happy with the care and activities X received. Staff are friendly and easy to talk to." "Since X came to live here we have found all the staff very helpful, supportive and caring."

We saw regular audits of the service were carried out to check staff delivered care and services in accordance with the organisations policies and procedures. Audit processes included the manager observing how staff delivered care and services to people.

There were also audits such as health and safety checks and the completion of care plans.

We saw systems had been put in place to ensure all concerns and complaints raised were recorded. People we spoke with told us if they raised any concerns with staff they were dealt with.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

Some people were not protected from the risks of unsafe or inappropriate care because records were not always sufficiently clear or detailed.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

During our last inspection we found improvements were needed to ensure people's care records were accurate and up to date. The manager sent us an action plan following our inspection that stated a full review of all care plans and risk assessments would be completed. We saw some evidence this review had taken place, this included a review of the records for a person who required specialist treatment for a pressure sore.

We found that whilst there had been some improvements in the records, there remained areas needing further improvement.

We looked at the care files for three people. Care records showed people had been assessed to check if they had mental capacity to make decisions. This was so they could be involved in making decisions about their care and treatment where appropriate.

We saw consideration had been given as to whether people were being deprived of their liberty under the Mental Health Act 'Deprivation of Liberty Safeguards'. This is where people who cannot make decisions for themselves need to be protected from being held or treated against their will. We saw applications for 'best interest' decisions were in process where this was appropriate. This included applications for consideration relating to the door on the unit being locked to keep people secure but which prevented people from leaving the unit or building.

One person's care file stated they had "poor food intake" and required vegetarian meals. The nutritional care plan showed it had last been reviewed in June 2014. It was not clear from the reviews whether the person had lost weight or not. We identified this was the case by speaking with staff.

The second person whose care file we viewed showed they were cared for in bed. There were no repositioning charts available to show the person's pressure relief was being managed to prevent sore areas developing. We could not see how often the person was being checked by staff. Staff told us this was happening on a regular basis and we saw

the person looked comfortable when we visited them. We identified the person was not eating and drinking well but there were no instructions for staff to record their food and fluid intake. Staff told us food and fluid intake charts were available for the person and were kept in the dining room. These showed the person was receiving regular food and fluids. We noticed the person's mouth care was in need of attention. Staff told us the person had a mouth infection. This information was not recorded in the care records to ensure all staff were aware of it and how it should be managed. We were told this information was kept with the medication records for the nurses as opposed to the care plan. We saw a 'short term care plan' was kept with the medication records. This stated the person's mouth should be cleaned 'regularly' as opposed to detailing the frequency this should happen. There was also no specific information about how the person's mouth should be cleaned to address the infection. We saw regular medication was being given to the person to treat their mouth infection.

A third care file we looked at contained a number of blank care plans. The meant there was limited information available to staff to ensure the person's needs were met. The unit manager told us this care file would be prioritised for completion to make sure staff had the information they required. We did not identify any concerns relating to this person during our inspection with the exception of their social care needs which we discussed with staff.

We were told by the deputy manager action would be taken to address the lack of information in the three care files we viewed. Some of the care plans were updated during our visit.

We saw there was a record of complaints being maintained by the home. The outcomes and ongoing actions were not always clear to show the complaint was being acted upon in a timely manner or had been resolved to the complainant's satisfaction.

We saw records of safeguarding referrals also did not always show the outcomes to show they had been investigated and acted upon appropriately.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: People were not protected against the risks associated with medicines because the provider was not ensuring that appropriate arrangements were in place to manage medicines.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: Some people were not protected from the risks of unsafe or inappropriate care because records were not always sufficiently clear or detailed. Regulation 20 (1) (a)

This section is primarily information for the provider

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 17 September 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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