Inspection Report

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

Rosecroft Residential Home

Westfield Drive, Workington, CA14 5AZ

Tel: 01900604814

Date of Inspection: 22 April 2014

Date of Publication: July 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Management of medicines	✖ Action needed

Details about this location

Registered Provider	Stilecroft (MPS) Limited
Registered Manager	Mrs Elizabeth Bedford
Overview of the service	Rosecroft is a residential care home that provides care and accommodation for up to 51 people. The home is situated in the town of Workington. Rosecroft is a large detached property set in its own grounds gardens with seating areas for people to enjoy the gardens and ample parking space. The accommodation is over two levels with a lift accessing the second floor.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

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 April 2014, observed how people were being cared for and talked with people who use the service. 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

The inspection was carried out by a pharmacist inspector. We set out to answer three key questions; Is the service safe? Is the service effective? Is the service well led?

Below is a summary of what we found. The summary is based on our observations during the inspection, discussions with staff and people who use the service, looking at supplies of medicines and looking at records.

If you want to see the evidence supporting our summary please read the full report.

Is the service safe?

We found that the service was not safe because people were not protected against the risks associated with use and management of medicines.

People did not receive their medicines at the times they needed them and in a safe way. Medicines were not administered and recorded appropriately, and were not kept safely.

Is the service effective?

We found that care plans for managing medicines were poor and staff did not have clear guidance available to them to make sure that people received appropriate care.

Is the service well led?

We saw that audits, or checks of medicines, were done to assess the way medicines were managed. However, we had concerns about the way medicines were handled and these were not identified or managed appropriately through the audits.

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 01 August 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 did not have appropriate arrangements in place to manage them.

We have judged that this has a moderate 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 undertook this inspection to follow up concerns that had been raised about the way medicines were handled. As part of this inspection we looked at medicines records, supplies and care plans relating to the use of medicines. We observed medicines being handled and talked to staff and people who used the service. We found that people who used the service did not receive their medicines in a safe way.

Medicines were not safely administered. We watched medicines being administered to people. We saw that the care worker administering medicines also had their own personal medicine on top of the medicines trolley. This increased the risk of medicines getting mixed up and people receiving the wrong treatment. We found some medicines were not given at an appropriate time in relation to food. For example we saw a medicine given with breakfast when it was prescribed 30 minutes to 60 minutes before food. This meant that people may not receive medicines that are safe or effective. Another person had swallowing difficulties and required thickened fluids. However, we saw their tablets being administered with sips of plain water. This placed them at risk of aspiration of the liquid that could cause choking.

Medicines were not handled appropriately. We looked at the handling of a blood thinning medicine for two people. The medicine required regular blood tests to determine the correct dosage. The blood test for both people was overdue and in one case this was overdue by eighteen days. We did not find any evidence that staff had followed this up effectively or had obtained professional advice on the dose of medicine to give until the test could be repeated. This meant that people were at risk of receiving inappropriate doses of the medicine and this could seriously affect their health.

We found that the morning medicines round took a long time to complete. We saw that

medicines were still being given at 11am and the next medicines round was due to take place at midday. We asked the care worker how medicines that were prescribed in the morning and again at midday were managed. She told us that if the interval between the two was too short, the midday dose would be either omitted or moved to a later time. This meant that people may not receive the full daily dose of medicines or may not receive them at the times that they are needed.

Appropriate arrangements were not in place in relation to the recording of medicines. We watched a care worker completing a sample of medicines administration records and some were not signed at the time that medicines were given. We saw eleven records completed for medicines that were given earlier in the morning and a further nine records were signed before people had taken their medicines. This was poor practice as mistakes could be made that could place people at risk of medication errors that may cause harm. We looked at administration records for two people who were prescribed inhalers. These failed to show that the inhalers were administered in the correct dosage.

We looked at the recording and the administration of creams. We saw that people had files in their rooms where care workers recorded the creams that they applied. The file also contained body maps that indicated where the creams were to be used. These records were poor. We saw records that referred to the application of creams when there was no evidence that the person was prescribed them. Other records showed that creams were not used in the correct way. We saw instructions for the application of creams from district nurses that were not followed. For example, the district nurse advised the application of a barrier cream four times a day to protect the skin for one person. However, the application of creams was recorded on twelve out of a possible ninety-seven times, and name of the cream was specified on only five of these occasions so we could not be sure that the appropriate cream was used on the other occasions. This increased the risk of skin damage.

Medicines were not kept safely. We saw medicines that were not stored at the correct temperature and this could make them unfit for use. One eye drop was incorrectly dispensed but this had not been identified by staff when received into stock. We saw eye drops in use that were out-of-date and this could leave the person at risk of eye infection. We found a cream that was in the incorrect box and this could result in a person getting the wrong treatment. We found an inhaler in the medicines trolley that should have provided treatment for one month at the prescribed dose. This was in poor condition and was dispensed in August 2012.

We looked at care plans for managing medication in detail for seven people. These were inadequate. Most care plans did not provide staff with appropriate guidance on the management of medicines or medical conditions. This meant that people may not receive appropriate care.

We checked medicines liable to misuse, called Controlled Drugs. We found that records and stock were correct showing that these medicines were handled correctly.

Monitoring of medication handling is necessary in order to identify and manage areas of concern promptly to protect people from harm. We saw checks, or audits, of the handling of medicines but these were inadequate and failed to identify and address the concerns raised at this inspection.

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 activity	Regulation
Accommodation for persons who require nursing or personal care	**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 did not have appropriate arrangements in place to manage them.

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 01 August 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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