

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

## Andrew Cohen House

River Brook Drive, Stirchley, Birmingham, B30  
2SH

Tel: 01214585000

Date of Inspection: 30 September 2014

Date of Publication:  
November 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

## Details about this location

Registered Provider	Birmingham Jewish Community Care
Registered Manager	Miss Josephine Stinton
Overview of the service	Andrew Cohen House provides accommodation and nursing care for up to 59 older people.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

## 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'.*

	Page
<b>Summary of this inspection:</b>	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
What we have told the provider to do	4
More information about the provider	5
<b>Our judgements for each standard inspected:</b>	
Management of medicines	6
<b>Information primarily for the provider:</b>	
Action we have told the provider to take	8
<b>About CQC Inspections</b>	9
<b>How we define our judgements</b>	10
<b>Glossary of terms we use in this report</b>	12
<b>Contact us</b>	14

## Summary of this inspection

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### Why we carried out this inspection

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We carried out this inspection to check whether Andrew Cohen House had taken action to meet the following essential standards:

- Management of medicines

This was an unannounced inspection.

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### How we carried out this inspection

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We looked at the personal care or treatment records of people who use the service, carried out a visit on 30 September 2014, talked with staff and were accompanied by a pharmacist.

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### What people told us and what we found

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A pharmacist inspector from the Care Quality Commission visited the home to look at medicine management. This was in order to follow up on a warning notice issued to the service following our previous inspection in July 2014.

We set out to answer one of our five questions, Is the service safe? Below is a summary of what we found. If you wish to see the evidence supporting our summary please read the full report.

We found that some improvements had taken place but there were not appropriate arrangements in place to ensure staff managed the risks associated with the use and management of medicines. Shortly after the inspection we also met with the provider representative, provider area manager and the home manager to discuss the issues and action that had been taken. We were told of further improvement actions that had been taken between the inspection and the meeting as well as other actions that were planned.

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

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### What we have told the provider to do

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We have asked the provider to send us a report by 25 November 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.

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## **More information about the provider**

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Please see our website [www.cqc.org.uk](http://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

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### 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 moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

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### Reasons for our judgement

A pharmacist inspector from the Care Quality Commission visited the home to look at medicine management. This was in order to follow up on a warning notice issued to the service following our previous inspection in July 2014.

We found that although the service had made some improvements towards meeting the warning notice we continued to find some areas of concern with medicine management. We therefore informed the management team that appropriate arrangements were still not being undertaken in order to manage the risks associated with the unsafe use and management of medicines.

We were told that regular checks were now being made by a pharmacy technician recently employed by the service to ensure people's medicines were managed safely. We found that improvements had been made to overall medicine stock control and the safe storage of medicines.

We were told that any medicine errors were dealt with immediately. We found that although medicine errors were being identified we continued to find further errors. In particular we found errors in the accurate recording of the administration of some people's medicines. We looked at the medicine administration records for 17 people living in the home. We noted that one person's medicine had not been signed for the administration of the medicine or a reason documented to explain why the medicine had not been given for a period of nine days. On checking the medicine container we observed that the medicine had been removed, however there was no record of administration. A second person's medicine administration chart had been signed for the administration of a medicine for a period of nine days although the medicine had not been supplied and was not available.

We also found a further two people had duplicate medicine administration record charts for the same medicine. We observed that both medicine administration record charts had been signed. The medicine records therefore documented that the two people had been given a prescribed medicine twice. Nursing staff we spoke with were unable to explain why the medicine records were not accurate.

Appropriate arrangements were not always in place to ensure that medicines were given according to the prescribers instructions. We found that one person who was prescribed a medicine to be given every three months had not been given it. There was no medicine administration record chart available for the medicine and the medicine was not available to give. The service had failed to ensure that there was an appropriate reminder system in place for obtaining and administering the medicine.

There was no consistent system of ensuring that any handwritten information recorded onto people's medicine administration record charts was accurate. We found that the majority of medicine administration record charts were printed by the supplying pharmacy however sometimes the service had to handwrite their own charts. We found that these handwritten medicine administration record charts did not always document up to date information. In particular we found that the month or year was not always documented onto people's charts.

We looked for supporting information for nursing staff to safely administer medicines to be given for anxiety or agitation 'when necessary' or 'as required'. We found that one person had no procedures available to provide guidance for members of staff who were not familiar with the person's individual behaviour.

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	<b>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010</b> <b>Management of medicines</b>
	<b>How the regulation was not being met:</b> The registered person was not protecting people against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping and safe administration of medicines. Regulation 13

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 25 November 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.

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**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.

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**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.

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**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

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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)

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### **(Registered) Provider**

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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'.

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### **Regulations**

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

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### **Responsive inspection**

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

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### **Routine inspection**

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

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### **Themed inspection**

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

## Contact us

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