Inspection Report

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

Burman House

Mill Road, Terrington St John, Wisbech, PE14 7SF

Tel: 01945880464

Date of Inspection: 02 October 2014

Date of Publication: November 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	Norse Care (Services) Limited
Registered Managers	Ms Chris (Sylvia) Baker-Jallow Mrs Patricia Ann McCallum
Overview of the service	Burman House provides accommodation and support for up to 32 older people.
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 2 October 2014, checked how people were cared for at each stage of their treatment and care and talked with staff.

What people told us and what we found

This inspection was conducted by a pharmacy inspector. The focus of the inspection was to answer one key question; is the service safe in respect of the management of people's medicines. During the inspection we spoke with one member of staff, the registered manager, the deputy manager and the regional director of the provider who was also present during the inspection.

Below is a summary of what we found.

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

Is the management of people's medicines safe?
The management of people's medicines was not safe. There were gaps in some of the records of medicine administration so we could not be assured people's medicines were being given to them as intended by their prescribers.

There was a lack of written information about the use of people's medicines for staff to refer to when administering medicines to people. This meant that there was a risk that staff could give them to people incorrectly.

Records did not confirm that medicines requiring refrigeration had been stored at appropriate temperatures. Therefore it was not clear that they were safe to use.

We noted that staff handling and administering people's medicines had received training and had been assessed as competent to manage people's 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 18 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.

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.

The service did not protect people against the risks associated with the unsafe use and management of medication by way of appropriate arrangements for the recording, using, safe keeping and safe administration of 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.

Reasons for our judgement

During the inspection our pharmacist inspector looked at how information in medication administration records for people living in the service supported the safe handling of their medicines. We conducted an audit of medicines which considered medication records against quantities of medicines available for administration. We found that there were gaps in some records of medicine administration for the evening before and on the morning of the day of our inspection. We also noted that records were not always complete when medicines were prescribed with variable doses such as 'one or two tablets'. Therefore, we could not be assured by the records that people living at the service were receiving their medicines as they should have been.

Some medicines had been prescribed to be given regularly. However, these had not always been given when they should have been. There were no records to determine why this had happened. In addition, where people were not administered their medicines because for example, they were still asleep in the morning, we found no evidence that staff had taken action to give them their medicines later in the day so that people received them as required.

We looked for supporting information to assist staff when administering medicines to individual people. We noted there was personal identification and information about known allergies and medicine sensitivities for people living at the home. For people living at the service who were managing and administering some of their prescribed medicines we noted there were recorded risk assessments in place, however, we noted some were in need of updating.

There was no written guidance for staff to follow about how people preferred to have their medicines administered or on how and when medicines prescribed for occasional

administration (PRN) should be given. This meant that some people may have received their medication inappropriately. For example, one person who had been prescribed a PRN medicine for the management of their anxiety, was being given this medicine each lunch-time and not on a when required basis as intended by the prescriber.

We found that medicines for oral administration were stored securely for the protection of people who were living at the service. However, daily temperatures of the refrigerator used to store some medicines were not being completed each day. We noted that recent records indicated medicines had been stored at temperatures above the accepted temperature limits. Therefore, we could not be satisfied that medicines requiring refrigeration were kept in environmental conditions which maintained their quality and therefore were still safe to use.

We noted that members of staff authorised to handle and administer people's medicines had recently had their competence assessed. Where issues had been identified, this had been highlighted and staff re-assessed. Records showed that staff had received medicine management training and the manager told us further training had been planned for the near future.

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: The service did not protect people against the risks associated with the unsafe use and management of medication by way of appropriate arrangements for the recording, 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 18 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.

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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