Review of compliance

Walton Care Limited The Grove Care Home	
Region:	North West
Location address:	40 Owen Street Rosegrove Burnley Lancashire BB12 6HW
Type of service:	Care home service with nursing
Date of Publication:	February 2012
Overview of the service:	The Grove is owned by Walton Care Limited. It is a purpose built single storey home with surrounding garden areas, an internal patio area and car parking to the front. The care home is suitably adapted for people with physical disabilities. Shops, pubs, churches and other amenities are within walking distance. The home can accommodate up to thirty eight people, either men or

	women who require nursing or personal care, and includes older frail people and younger people

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

The Grove Care Home was not meeting one or more essential standards. We have taken enforcement action against the provider to protect the safety and welfare of people who use services.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 09 - Management of medicines

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 21 November 2011, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

On the day of our visit, the nurse we spoke with about medication told us that there was only one nurse responsible for administering the medicines to all the people living in the service, whether they were receiving personal care or nursing care. This meant that it took a long time to administer all the medicines and we saw that some people did not get their morning medicines until after 11:30am. We were told that sometimes it could be later, especially if the nurse was frequently disturbed or if there was a serious incident or emergency to deal with.

One person told us, "I think I get what (medicines) I'm supposed to, but I don't know what I take now I don't look after them myself". Another person said, "Sometimes I have to wait for my painkillers, but it's not their fault, they try their best".

What we found about the standards we reviewed and how well The Grove Care Home was meeting them

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

The service does not protect people against the risks associated with the unsafe use and management of medication and needs to address this by making appropriate arrangements for the safe recording, handling, administration and use of medicines.

Actions we have asked the service to take

We have taken enforcement action against Walton Care Limited.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

In a previous review, we suggested that some improvements were made for the following essential standards:

- Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

- Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

- Outcome 07: People should be protected from abuse and staff should respect their human rights

Please see previous reports for more information about previous reviews.

What we found
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are major concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
Most medicines were stored in locked cupboards and trolleys that only authorised staff had access to.

The medication administration records (MARs) were not kept locked away when not in use and were left in the dining room where they could be accessed by anyone, including people living in the service or visitors.

On the day of our visit, one nurse was responsible for administering the medicines to all the people living in the service, whether they were receiving personal care or nursing care. This meant that it took a long time to administer all the medicines and we saw that some people did not get their morning medicines until after 11:30am. We were told that sometimes it could be later, especially if the nurse was frequently disturbed or if there was a serious incident or emergency to deal with.

One person told us, "I think I get what (medicines) I'm supposed to, but I don't know what I take now I don't look after them myself". Another person said, "Sometimes I have to wait for my painkillers, but it's not their fault, they try their best".

Other evidence
We looked at a sample of Medication Administration Records (MARs), stock and other records for people living in the service.

Records were unclear and it was not always possible to see whether medicines had been given correctly. This was because the amount received in to the home had not always been recorded; the actual dose given (e.g. one or two tablets) had not been stated; older stock from the previous month(s) had not been carried forward and the time medicines were given was not recorded accurately.

We found that some medicines had not been given because stock had run out and new supplies not obtained quickly enough. In two examples, it was more than 7 days before new supplies were obtained. There was no explanation why other medicines had not been given as prescribed. Without clear accurate records, people are at risk of not receiving the correct medication to meet their needs.

Care workers did not always follow special instructions, for example 'give 30-60 minutes before meals' or 'take with or after food'. This meant that medicines were not always given at the right time with regard to food and drink, and this could stop them from working properly. Some people were prescribed medicines, for example painkillers, that were to be taken only when required. There was not enough information for care workers to follow to make sure these were given consistently and correctly.

We looked at the records and stock for two people who were prescribed Controlled Drugs (very strong medicines that need special storage and recording requirements). We found in both cases that weekly pain relief patches were not changed on the correct days. In one example the patch was only changed 8 days after it was due and in another the patch was changed 14 days late. This meant that these people were not getting as much pain relief as they should. Failing to give and/or use medicines as prescribed places the health and wellbeing of people living at The Grove at serious risk of harm.

We looked at the manager's audits (checks) on the medicines system within The Grove. We were shown an audit that had been completed recently, but this did not check care workers practice or other key aspects of handling medicines safely. As a result, some discrepancies and areas of concern had not been identified or addressed. The manager told us that further training for care workers who handle medicines was planned.

Our judgement
The service does not protect people against the risks associated with the unsafe use and management of medication and needs to address this by making appropriate arrangements for the safe recording, handling, administration and use of medicines.

Action
we have asked the provider to take

Enforcement action we have taken

The table below shows enforcement action we have taken because the service provider is not meeting the essential standards of quality and safety shown below. Where the action is a Warning Notice, a timescale for compliance will also be shown.

Enforcement action taken			
Warning notice This action has been taken in relation to:			
Regulated activity	**Regulation or section of the Act**	**Outcome**	
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	The service does not protect people against the risks associated with the unsafe use and management of medication and needs to address this by making appropriate arrangements for the safe recording, handling, administration and use of medicines.		20 January 2012
Regulated activity	**Regulation or section of the Act**	**Outcome**	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**

	The service does not protect people against the risks associated with the unsafe use and management of medication and needs to address this by making appropriate arrangements for the safe recording, handling, administration and use of medicines.		20 January 2012
Regulated activity	**Regulation or section of the Act**	**Outcome**	
Diagnostic and screening procedures	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	The service does not protect people against the risks associated with the unsafe use and management of medication and needs to address this by making appropriate arrangements for the safe recording, handling, administration and use of medicines.		20 January 2012

What is a review of compliance?

By law, providers of certain adult social care and health 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 Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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