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:	June 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 meeting all the essential standards of quality and safety inspected.

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 to check whether The Grove Care Home had taken action 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 12 April 2012, talked to staff and talked to people who use services.

What people told us

Medicines, including controlled drugs, were stored safely and securely and were only accessible to authorised staff. This protects people living in the home and helps to prevent the medicines from being misused.

People generally received their medicines at the right time and in a safe way.
Medicines records were now stored securely and with respect to people's privacy and dignity.

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 provider was meeting this standard. People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Other information

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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that 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.

A moderate impact means that 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.

A major impact means that 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.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

The provider is compliant 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
In view of the major concerns identified in this outcome area at our previous visit on 21st November 2011, the Care Quality Commission served a Warning Notice in relation to the management of medicines within the service. Following this, we received an action plan from the Manager. The purpose of our visit was to check whether or not these actions had been carried out and whether our concerns had been successfully

addressed.

We looked at a sample of Medication Administration Records (MARs), stock and other records for people living in the service. We also talked to the manager and the nurse on duty in relation to the management of medication.

Appropriate arrangements were now in place in relation to the recording of medicine. We saw that medicines records were generally clear and complete. The manager had recently introduced some new paperwork to help account for medicines and record when and why medicines had not been given. This was working well and medicines could be accounted for easily.

Medicines were administered safely and were given to people appropriately. Appropriate arrangements were in place in relation to obtaining and disposing of medicines. There were adequate supplies of all medicines prescribed for people living in the service and unwanted medicines were disposed of in line with current guidance.

We looked at records of audits (checks) that showed how the manager checked that medication was administered, recorded and handled correctly. The manager had recently introduced a new system of auditing and this was proving to be effective. There was evidence that action had been taken to address discrepancies and concerns that had been identified in order to improve the way that medicines were handled within the home.

Where appropriate staff had recently had refresher training in medicines management and had completed competency assessments in order to ensure they had the skills necessary to handle and record medicines safely. However the provider may find it helpful to train senior care staff to administer medication to people receiving only personal care. This would reduce the workload on the nurse on duty and extend the skills of other staff.

Our judgement
The provider was meeting this standard. People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. 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

Document purpose	Review of compliance report
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