CareQuality Commission

Review of compliance

Sunshine Care Homes Limited Majestic Care Home	
Region:	North West
Location address:	192 Queens Promenade Bispham Blackpool Lancashire FY2 9JS
Type of service:	Care home service without nursing
Date of Publication:	August 2011
Overview of the service:	The Majestic is registered to provide personal care for a maximum of 19 older people. The home is an adapted property, which is situated on the promenade at Bispham. The accommodation comprises of 19 single bedrooms, of which 14 have en-suite facilities. A stair lift enables people to gain access between the ground and first floor.

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

Our current overall judgement

Majestic Care Home was not meeting one or more essential standards. Improvements are needed.

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 July 2011, talked to staff and talked to people who use services.

What people told us

People wishing to self-administer medication were able to do so. One person who had chosen to self-administer some of their medicines told us they knew what their medications were for as they had used them for a long time. Care workers told us that they did not keep homely remedies for the treatment of minor ailments. But, one person told us that care workers had acted quickly when they needed something from the doctor.

What we found about the standards we reviewed and how well Majestic 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 fully protect people against the risks associated with the unsafe use and management of medication by means of the making of the appropriate arrangements for the recording, handling, administration and use of medicines.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

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. Any regulatory decision that CQC takes 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

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
People wishing to self-administer medication were able to do so. One person who had chosen to self-administer some of their medicines told us they knew what their medications were for as they had used them for a long time. But, we found a lack of written information about how safe self-administration was supported. Care workers told us that they did not keep homely remedies for the treatment of minor ailments. But, one person told us that care workers had acted quickly when they needed something from the doctor.

Other evidence
We looked at medicines administration. We found there was insufficient written individual information in support of the safe administration of medicines. For example, there was a lack of information about the use of medicines prescribed 'when required' and about the use of prescribed external preparations (creams). Similarly, there was a lack of information about any support people may need to safely self-administer medication and care workers spoken with were unclear when asked, which medicines one person self-administered. We observed that lunchtime medicines were passed to people directly in care workers hands because the home had no medicines pots. Arrangements were not in place to ensure that any special label instructions such as 'before food' were followed.

We looked at medicines record keeping. We found gaps in the records of medicines receipt, administration and disposal that meant it was not always possible to tell

whether medicines had been given correctly. On occasion several medication doses were missed because there were none left in stock. Changes to people's medicines were poorly recorded and unexpected changes to peoples medicines were not queried or confirmed. For example, painkillers and a cream had been delivered for one person but care workers did not know where the cream was for, and one care worker did not know there were any painkillers. Neither medication had been used. Where records showed several doses of medication had been missed the prescribers advice was not sought, to ensure peoples treatment was kept under review.

We saw that medicines were not safely stored because the cupboard lock was missing. There were two unlabelled medicines in stock. Care workers knew who they were for, but could not check the directions prior to administration increasing the risk of mistakes. And, suitable arrangements were not in place for the storage and handling of controlled drugs.

The manager completed monthly medicines audits but these had not been effective in identifying areas where medicines handling fell short of the homes medicines policy.

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

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

<table>
<tr><th>Regulated activity</th><th>Regulation</th><th>Outcome</th></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care</td><td>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 09: Management of medicines</td></tr>
<tr><td colspan="2">How the regulation is not being met:
The service does not fully protect people against the risks associated with the unsafe use and management of medication by means of the making of the appropriate arrangements for the recording, handling, administration and use of medicines.</td></tr>
</table>

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

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 within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

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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