Review of compliance

Four Seasons (Bamford) Limited Holbeche House Care Home	
Region:	West Midlands
Location address:	Wolverhampton Road Wall Heath Kingswinford West Midlands DY6 7DA
Type of service:	Care home service with nursing
Date of Publication:	July 2012
Overview of the service:	The home can provide accommodation for up to 49 people who require nursing care.

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

Our current overall judgement

Holbeche House Care Home was not meeting one or more essential standards. Action is 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 6 June 2012, checked the provider's records, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We carried out this review to check on the care and welfare of people using the service. The home had a nursing unit and a separate dementia care unit.

People do not always receive their medication at the times they need them. Medicines are not stored safely.

What we found about the standards we reviewed and how well Holbeche House 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 not meeting this standard. We judged that this had moderate impact on people using the service. People were not fully protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

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 found that action was needed 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
- Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care
- Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

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 non-compliant with Outcome 09: Management of medicines. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
The safe handling of medicines was assessed by a pharmacist inspector. We spoke with three members of staff, looked at the storage of medicines and19 people's medicine records. We spoke with a few people using the service but did not discuss their medicines with them because they were not able to communicate verbally with us in a meaningful way.

Appropriate arrangements were being put into place to ensure that people's prescribed medicines were reviewed and changed as their needs or condition changed. We looked at 19 people's Medicine Administration Record (MAR) charts, which document when medicines are given to people. On one unit we found that seven people were not always taking their prescribed medicines because they refused their medicines or were asleep. We were told that two people had stopped taking prescribed medicines which had made them sleepy during the day but now they were more awake and alert. A member of staff told us that they had asked the GP to review six people's prescribed medicines because they were not compliant in taking them. This has been agreed by a Primary Care Trust (PCT) Pharmacist who told us that they were going to review people's prescribed medicines with the GP. We were not able to confirm the date of completing these reviews at the time of writing this report.

Person centred information relating to people's medicines was available. In particular we saw information was provided for medicines that required extra checks or special administration directions. One person had been ill and could not take their prescribed

medicine, which required special checks. We saw a record which documented that staff had contacted a specialist healthcare professional to ask for advice to ensure the person was protected from harm. We spoke with two staff who were able to tell us about individual people's medicines and their related health conditions.

Other evidence
Arrangements were not in place for the safe storage of people's medicines. One medicine store room was not secure from unauthorised access. The medicine cupboard inside this room was unlocked. The home manager told us that a secure lock to the room would be fitted immediately. The medicine refrigerator on one unit was broken and was located in an open office. We were told that a new refrigerator was on order but had not been delivered. Alternative arrangements for the safe storage of people's medicines had not been taken. This means that there was increased risk of access to people's medicines which were not secure.

Medicines were stored within a safe temperature range in two medicine storage rooms. We looked at the daily temperature records for both rooms, which recorded temperatures below 25 degrees C. This shows that appropriate arrangements were in place for the storage of medicines within a safe temperature range.

Appropriate arrangements were in place to ensure that regular prescribed medicines were available to give to people. The provider may find it useful to note that one person did not have one of their prescribed medicines, which had been prescribed for pain relief when necessary. It was not available to give because it had not been ordered. A member of staff told us that the person did not require the medicine very often but agreed that the medicine should be available and would order it immediately. We found that regular prescribed medicines for people were available to give, however medicines that were not given regularly were not always ordered and obtained in sufficient time.

Systems were not always in place to ensure that people were given their medicines as prescribed. One person was prescribed a medicine to be given once a week. We looked at the MAR chart and saw that there was no record of the medicine being given for one week or a reason to explain why it had not been given. All other prescribed medicines for the person had been recorded as given. The medicine was still in the packaging and had not been removed. One member of staff could not explain what had happened. This means that appropriate procedures were not always in place to ensure that people were being given their medicines as prescribed which increases the risk of harm to people.

Our judgement
The provider was not meeting this standard. We judged that this had moderate impact on people using the service. People were not fully protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage 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.

Regulated activity	Regulation	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 is not being met: The provider was not meeting this standard. We judged that this had moderate impact on people using the service. People were not fully protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.	

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 7 days of the date that the final review of compliance report is sent to them.

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.

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

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