# Inspection Report

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

# Princess Lodge Limited

11 High Street, Princes End, Tipton, DY4 9HU

Tel: 01215571176

Date of Inspection: 09 January 2014

Date of Publication: February 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 | Princess Lodge Limited |
| Registered Managers | Mr. Frank Brown<br>Mrs. Jayne Elizabeth Whitehouse |
| Overview of the service | Princess Lodge is registered to provide accommodation and nursing care to a maximum of 36 people. People living there have a range of conditions related to old age which may include dementia. |
| Type of service | Care home service with nursing |
| Regulated activities | Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury |

# 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 9 January 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with staff, were accompanied by a pharmacist and reviewed information sent to us by commissioners of services.

### What people told us and what we found

We used a number of different methods to help us understand the experiences of people using the service, because the people using the service had complex needs which meant they were not able to tell us their experiences.

We found the service had poor systems in place to ensure the safe management of medicines. We found poor medicine administration and disposal records meant that we were unable to see if people were having their medicines administered as prescribed. We found the lack of information about how medicines should be administered meant that the administration of medicines might not have been safe or effective.

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 04 March 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.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage 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

Appropriate arrangements were in place in relation to obtaining medicines. We found that the procedures in place for obtaining medicines ensured that medicines were available for administration at the prescribed times. The availability of medicines should ensure that the people who used the service were able to receive the treatments that had been prescribed by their doctor.

Appropriate arrangements were not in place in relation to the recording of medicines. During the inspection we looked at nine out of 24 medicines administration records. This was so that we could see if these records could indicate whether people were receiving their medicines as prescribed by their doctor. We found that the service had a procedure to record the receipt of medicines on to the medicines administration records. We found that the service was not always recording the receipt of the medicines received and therefore we they were unable to carry out an audit to see if the medicines had been administered as prescribed. Where the receipt of medicines had been recorded we found that there were some discrepancies between the quantities of medicines that remained, according to the records and the physical quantities found. These discrepancies could indicate that some people had not received their medicines as prescribed. We also found that the service was using medicines that were carried over from the previous 28 day administration cycle, but had not accounted for these in the current records. All of these issues meant that the service was not able to evidence that the people using the service were receiving their medicines as prescribed.  Poor record keeping of medicines could affect the health and welfare of people who lived in this service.

Medicines were not disposed of appropriately. We found that where people had refused to take their medicines the service was making a record of this on the administration records. As the people had not taken these medicines we expected to find these medicines

remaining in the containers they had been dispensed in, however some of the medicines were not present.  We therefore examined the disposal records to see if these medicines could be accounted for. Unfortunately the disposal records were not able to show that these medicines had been disposed of. The provider does not have a system in place to ensure that the disposal of medicines was accurately recorded and therefore there were medicines that could not be accounted by the service.

We found that the service had a framework to record the additional information required to ensure that 'when required' medicines were managed safely. We found that in some cases this framework had not been put into place so there was no written guidance on how to manage these medicines. We also found that where the framework was in place sometimes the information recorded was sufficient and sometimes it wasn't sufficient to ensure that these medicines were managed safely. The lack of information about how medicines should be managed may result in people at the service not getting their medicines when they need them.

Medicines were not administered safely. We found that there was no written information about how to specifically administer medicines through a Percutaneous Endoscopic Gastrostomy (PEG) tube. When medicines are being administered through this tube we would expect the service to have a written procedure in place. This procedure should describe how to prepare each medicine before it is flushed down the tube and how much fluid should be used to prevent the tube from becoming blocked after the administration of each medicine. The service was therefore unable to demonstrate that medicines given in this way was being carried out safely by the staff.
Medicines were kept safely. We found that medicines were being kept secure, which meant that people using and visiting the service were protected against the risks associated with the inappropriate administration of medicines. We also found that medicines were being stored at the correct temperature. The storage of medicines at the correct temperature meant that they will be effective in treating the conditions they had been prescribed for.

We found that systems were now in place to ensure the safe handling and administration of Controlled Drugs. This meant that people using the service would be protected against the risks associated with the handling and administration of Controlled Drugs.

We observed the administration of medicines over the lunchtime period. We saw that the medicine administration records were being completed before the administration of the medicines had taken place. We also saw that medicines were being handled by the member of staff during the administration process but was not wearing any protective gloves. We spoke with the management team about this and they said they were about to implement a system of assessing the competency of the nursing staff to administer medicines safely. Regular assessments of the nursing staffs' competency to administer medicines safely would protect people using the service from the risks associated with the poor handling of medicines.

We found that the service did not have a robust audit system in place to ensure that people using the service were receiving their medicines as prescribed. As a consequence the discrepancies seen during the inspection had not been identified by the service. The lack of a robust audit system was failing to protect people against the risks associated with the unsafe use and management of medicines.

**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 activities | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | **Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Management of medicines** |
| | **How the regulation was not being met:**<br><br>People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. |

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 04 March 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.<br>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.<br>We monitor the implementation of action plans in these reports and, if necessary, take further action.<br>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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