Inspection Report

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

Horfield Lodge

Kellaway Avenue, Horfield, Bristol, BS7 8SU

Tel: 01179166630

Date of Inspection: 11 September 2013

Date of Publication: November 2013

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Management of medicines	✖ Enforcement action taken

Details about this location

Registered Provider	Methodist Homes
Registered Manager	Dr. Sarah Batchelor
Overview of the service	Horfield Lodge is a location of Methodist homes which provides accommodation for up to 75 people. The accommodation is purpose built and is arranged over three floors.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures 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 to check whether Horfield Lodge had taken action to meet the following essential standards:

- Management of medicines

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 11 September 2013, observed how people were being cared for and talked with people who use the service. We talked with staff.

What people told us and what we found

One person who told us that although staff looked after their medicines they were able to take their pain relieving medicines at a time that suited them. We heard staff ask people if they needed medicines prescribed when required for pain relief.

Arrangements in place for ordering medicines were not always adequate to ensure a supply was always available. We saw three examples where someone had been unable to take one of their medicines for more than 2 days because a new supply had not been received.

Some people were prescribed medicines to be given 'when required'. Additional information was not always available to ensure that staff were able to give these medicines appropriately.

We found that improvements were needed to ensure that people were better protected from the risks associated with medicines.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have taken enforcement action against Horfield Lodge to protect the health, safety and welfare of people using this service.

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 ✖ Enforcement action taken

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 for the obtaining, recording and safe administration of some medicines.

Where areas of non-compliance have been identified during inspection they are being followed up and we will report on any action when it is complete.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

At our last inspection in May 2013 we found that people were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the obtaining, recording, and safe administration of medicines. The provider sent us an improvement plan to explain the action they were taking to address these concerns. During this inspection we found that some improvements had been made but further action was required.

Most medicines used in the home were looked after and given by staff. We spoke to one person who told us that although staff looked after their medicines they were able to take their pain relieving medicines at a time that suited them. We saw staff giving two people their morning medicines in a safe and respectful way. We heard staff ask one person prescribed pain relief, to be taken when required, whether they needed this medicine. This meant that people could have their medicines in a way that suited them.

The arrangements for ordering medicines were described in the home's medicines policy. However we saw that they were not always adequate to ensure that a suitable supply of medicines were available. The home used an electronic system which prompted staff to reorder medicines if the quantities in stock reached a low level. We saw three examples where a medicine had been unavailable for more than two days for people on the nursing floor. One person was prescribed iron tablets that had been unavailable for the previous

16 days. The arrangements in place for ordering medicines were not always followed. This could put people's health at risk if their prescribed medicines were not available for them.

We looked in detail at the supply of 11 medicines prescribed for one person on the nursing floor. Of these medicines only two had the correct amount in the home, as indicated by the home's electronic system. There were significant differences for five of these medicines which increased the risk that these medicines could run out before staff were alerted to reorder them.

Staff on the ground floor and the care suite told us that they made regular checks of the numbers of medicines in stock to ensure they agreed with the electronic system. However the manager told us that the home relied on the electronic system to check the stocks of medicines and did not need to make regular checks themselves. This was confirmed by the provider's medicines policy. This increased the risk that people's prescribed medicines would not be available for them. People's health could suffer as a result of this.

Suitable arrangements were in place in relation to the recording of medicines. Staff made an electronic record of the medicines that they gave to people. Each month a copy of the record was printed so that it was easily accessible and could be checked. Staff we spoke to were familiar with how to use the system. The manager told us that checks had been done to make sure that staff were able to use the system safely. The pharmacy provided daily summaries of information from the previous day's records. These were checked by the manager and available on each floor so that staff could address any problems identified.

Codes were available for staff to record the reason why, if a person had not taken their prescribed medicines. We saw several examples where the correct code had not been used. For example staff had recorded that a medicine prescribed to be given regularly was 'not required' when in fact the person had declined to take the medicine. This meant that some records did not give an accurate picture to identify potential problems and suitable action would not be taken.

We saw two records which did not confirm that people had been given their medicine correctly. For one person we saw two examples where the dose of medicine recorded as being given did not agree with the dose prescribed for that day. Staff told us that this could have been a recording error with the electronic system rather than an incorrect dose being given. Another person had been prescribed an antibiotic. The record showed that 15 doses of medicine had been given but only eight doses had been recorded as being in stock. It was not clear whether this person had been given their antibiotic correctly so that it could work effectively.

Some people had been prescribed medicines to be given 'when required'. Dose instructions for these medicines included how often they could be given. We saw some examples of the additional information available for staff which would help them to give the medicine in a safe way. However we looked at records for one person prescribed a medicine 'when required' to treat a particular medical condition. There was some general information about treating this medical condition. This was not specific to this person and did not include any information about how and when the medicine should be used. Another person was prescribed a strong medicine for pain relief, to be given when required. We could find no written information about when this medicine should be used. Staff we spoke to were not clear when it should be used. This person had been given one dose of this

medicine in August. It was not clear from the records available why the medicine had been given. There was no information about treatment of pain in this person's care file. A lack of written information in these cases increased the risk that people would not always benefit from the safe use of these medicines.

Suitable arrangements were in place for storing medicines safely on each floor of the home. Medicines fridges were available and records showed that these were kept at a safe temperature. Trolleys were available for transporting medicines around the home securely. Suitable storage was available for controlled drugs which need additional security. Records showed that these medicines had been looked after safely.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 25 October 2013 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
Treatment of disease, disorder or injury	**How the regulation was not being met:** People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the obtaining, recording and safe administration of some medicines, Regulation 13.

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

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. 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. We monitor the implementation of action plans in these reports and, if necessary, take further action. 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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