Review of compliance

Bondcare Shaftesbury Limited Donwell House	
Region:	North East
Location address:	Wellgarth Road District 2 Washington Tyne and Wear NE37 1EE
Type of service:	Care home service with nursing
Date of Publication:	August 2012
Overview of the service:	Donwell House is a purpose built care home situated in the village of Washington Tyne & Wear. It is registered to accommodate up to 63 people who need nursing, social and personal care, some of whom may also have dementia. The service is registered with the Care Quality Commission for the regulated activities of accommodation for persons who

	require nursing or personal care.

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

Our current overall judgement

Donwell House 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 16 July 2012, observed how people were being cared for, looked at records of people who use services and talked to staff.

What people told us

We spoke to one person who used the service about their medicines at this visit. The person confirmed that care workers gave them the right amount of support and help with their medicines.

What we found about the standards we reviewed and how well Donwell House 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 found that the home 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, storing, and safe administration 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. 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 10: People should be cared for in safe and accessible surroundings that support their health and welfare

- 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
We spoke to one person who used the service about their medicines at this visit. The person confirmed that care workers gave them the right amount of support and help with their medicines.

Other evidence
The purpose of this inspection was to ensure medicines were looked after and given to people safely. The inspection was completed by a pharmacist inspector.
All of the people who use this service have their medicines given to them by the staff. As part of our review we looked at medicines records and supplies in detail for eight people using the service. We checked eight of the administration records together with receipt records and these showed us that people were not always receiving their medicines correctly. For most records we found more of the medicine was remaining than the administration records indicated, meaning some doses of medicine recorded as given had not actually been given, Medicine for three people was not available in the home and could not be given. A medicine for pain relief for another person was not given for two days during a weekend because it was not written on the medicine administration record (MAR).
We saw medicine records were not accurately maintained. For medicines prescribed with a choice of doses to give, the records did not always show how much medicine the person had been given at each dose. Also, when creams and other topical preparations were applied the records were incomplete and we were not able to confirm these were being used as prescribed.

Inaccurate and incomplete record keeping demonstrates people are not protected against the risks associated with the unsafe use and management of medicines.
For some people we found where medicines were prescribed to be given 'only when needed, the individual when required protocols, (administration guidance to inform staff about when these medicines should and should not be given), was not always available. This guidance helps to ensure staff administer these medicines in a safe, consistent and appropriate way.
All medicines were stored securely, however there were gaps in the record kept of room and fridge temperature, and therefore it was not possible to confirm medicine was stored at a suitable temperature, so as to protect the people who use the service.
Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss however these showed two medicines in stock which had been destroyed and the appropriate records had not been made.

Our judgement
The provider was not meeting this standard. We found that the home 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, storing, and safe administration 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.

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: We found that the home 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, storing, and safe administration of medicines.	
Diagnostic and screening procedures	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: We found that the home 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, storing, and safe administration of medicines.	
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: We found that the home 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, storing, and safe administration of 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 14 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

Document purpose	Review of compliance report
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