Coxbench Hall Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 4 January 2017. The service was last inspected on 14 and 19 September 2016. When we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the provider not having effective systems to ensure people's medicines were managed safely and the completion and updating of care plans and risk assessments. At this inspection we found that some improvements had been made.

Coxbench Hall is registered to provide accommodation and personal care for up to 39 people. At the time of our inspection there were 35 people living there. The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Daily audits of medicines were not always recorded and the storage of medicines was not in line with the home's policy. This meant staff could not be sure that medicines were given appropriately and remained safe and effective to use.

At this inspection we found improvements had been made and the concerns raised around the Warning Notice issued had been resolved. However, we identified other areas where improvements needed to be made in the management of medicines. You can see what action we told the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Medicines were not managed safely all of the time.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems in place to monitor and assess the quality of care had improved but did not always identify gaps in medicines management.

Care plans were updated and contained appropriate risk assessments.

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Detailed findings

Background to this inspection

We carried out this focussed inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the quality of the service and to provide a rating for the service under the Care Act 2014.

This inspection place on 4 January 2017 and was unannounced. The inspection visit was conducted by two inspectors, one of whom was a pharmacy inspector.

Before our inspection visit we reviewed the information we held about the service including notifications the provider sent us. A notification is information about important events which the service is required to send us by law. For example, notifications of serious injuries or allegations of abuse.

This was a focussed inspection following the comprehensive inspection which took place on 14 and 19 September 2016. The team inspected the service against two of the five questions we ask about services. Is the service safe and is the service well-led. This is because the service was not meeting some legal requirements.

During the inspection we spoke with the registered manager and deputy manager. We reviewed the Medicine Administration Records (MAR's) for 12 people and checked the stocks of medicine for four people. We also looked at the medicine auditing process.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 14 and 19 September 2016 we found medicines had not been managed safely. Discrepancies on Medicines Administration Charts (MAR) were identified and this was identified again at this inspection although some improvements had been made. Staff told us this information was passed to senior carers responsible for medicines administration. However, we did not see any evidence of this or actions that were taken to ensure this discrepancy did not happen again.

At this inspection we found some improvements had been made in the storage of medicines. However, where some medicines required special storage these guidelines were not always adhered to. For example, where medicines required to be stored in a refrigerator they were not stored at the correct temperature. Refrigeration temperatures were not being recorded in line with the home's policy. Maximum and minimum temperatures were not recorded which meant staff could not be sure medicines given to people were effective and safe to use. Also, the date of opening medicines was not always recorded which meant staff could not be sure when medicines needed to be disposed of. We found one medicine had been removed from the fridge but there was no record of the date it had been removed. This meant this medicine could have been out of the fridge for longer than was safe. We saw medicines had not been stored in line with the manufacturers guidelines and this put people at risk from receiving unsafe or ineffective medicines.

We looked at 12 MAR charts and found three did not contain all the required staff signatures. We found one person had received their medicines as prescribed but staff had not made an accurate record of this. Converseley, for another person the remaining stock of medicines showed that staff had not administered medicines as prescribed. In addition, medicines with a short expiry date, when opened, were not dated to ensure they were administered while the medicine was still effective. We were unable to identify clearly whether people had received their medicines as prescribed. This meant people were being put at risk associated with inappropriate treatment.

Where people required moisturising or pain relieving creams and ointments applied to their skin we found administration records did not clearly indicate where the creams had been applied. This meant it was unclear from records whether people were getting their creams as prescribed. This put people at risk from skin breakdown and discomfort.

Where medicines were required to be given 'as required' there were not consistent records kept of these. This meant people were at risk from being given medicines within a shorter timescale than was appropriate.

The above evidence shows there was inconsistent administration of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment.

Medicine stock levels were checked at each medicine round to help ensure an effective stock management system. We also saw that medicines were stored securely. One person managed their own medicines without help from staff. We saw a risk assessment had been conducted and the person was provided with

secure storage for their medicines to support and promote their independence in the home.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection on 14 and 19 September 2017 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found some improvements had been made and this regulation was now met. We found there were systems in place for the monitoring of medicines. We saw medicines were stored securely and medicine stock levels were checked at each medicine round to help ensure an effective stock management system. When variable doses of medicines were prescribed we saw the MAR charts detailed how much medicine had been given to a person on each occasion they had been given it. There was a policy in place to support people and staff when medicines needed to be given covertly and we could see this had been followed. Giving medicines covertly means they administered without the person being aware of this, for example in food.
However, there were not consistently accurate records of when people had received their medicines. Audits had failed to alert the registered manager to this. This meant we could not be sure people were receiving medicines which were effective and safe.

We found there were effective systems in place to assess, monitor and review people's care records and ensure their safety. Care records had been updated and risk assessments were complete. There was a system in place for ensuring continued improvement of care records.

The rating for well-led has been reviewed and remains at requires improvement. The service will need to demonstrate consistent good practice over time. We will check this during our next planned comprehensive inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe management of medicines. Medicine Administration Records not fully complete and medicines not stored in a way which ensured they were safe and effective.