

Edge Hill Limited

# Edge Hill Rest Home

## 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

### About the service

Edge Hill is a residential care home providing personal care for up to 36 people. At the time of our inspection there were 22 people living at the home. The home is an adapted building set in its own grounds. Accommodation is over two floors.

### People's experience of using this service and what we found

The provider's quality assurance and monitoring system for the management of medicines was not effective. This meant the storage and administration of medicines was not always safe and people were put at risk of harm.

The registered manager carried out monthly medicines audits. However, they were not robust enough, as they had not identified the concerns we found during our inspection. Staff who gave out medicines had been trained and assessed as competent to do this. However, we found concerns around the administration of medicines. This showed the training and competency checks were not robust.

Medicines were not always stored within the recommended temperature range. If medicines are not stored properly they may not work in the way they are intended.

The controlled drugs register had not always been completed correctly and in line with controlled drugs regulations.

Medicines administration records (MARs) had not always been completed accurately. We could not be sure people had received their medicines as prescribed. Some people had not received their medicines at the correct time. Although this was a dispensing error, by a pharmacist, the service had not taken any steps to seek clarification about the problem.

Risk assessments had not been completed for two people who managed their own medicines. This meant staff could not be sure the people were capable of looking after their medicines themselves.

Body maps to show where creams should be applied and where pain patches should be placed were not completed.

Some people with swallowing difficulties have their drinks thickened to prevent them choking. There was a lack of detail in people's care plans about how much fluid thickener should be used. Fluid thickeners were not always stored securely.

We have made a recommendation about the way the way the service re-orders PRN medicines.

### Rating at last inspection

The last rating for this service was good (report published 10 July 2018).

#### Why we inspected

The inspection was prompted by concerns raised at an inquest about some aspects of the management of medicines at the home. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led. We looked specifically at the management of medicines and the oversight of the registered manager and provider of these aspects of care.

We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence the provider needs to make improvements. Please see the Safe and Well-led sections of this report.

#### Enforcement

We identified breaches in relation to the management of medicines and governance. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Edge Hill on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### Follow up

Following the inspection we took action to ensure the provider improved the management of medicines. We asked the local Clinical Commissioning Group (CCG) medicines optimisation team to carry out an audit of the management of controlled drugs at the home. We informed the local authority of our inspection findings.

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

**Requires Improvement** ●

# Edge Hill Rest Home

## Detailed findings

### Background to this inspection

#### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

#### Inspection team

The inspection was carried out by an inspector, an inspection manager and a medicines inspector.

#### Service and service type

Edge Hill is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

#### Notice of inspection

This inspection was unannounced.

#### What we did before the inspection

We reviewed information we had received about the service since the last inspection. This included information we received from a Coroner, following an inquest. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

#### During the inspection

We reviewed a range of documents relating to the management of medicines. We spoke with the registered

manager and a senior care worker.

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

### Using medicines safely

- The Controlled Drugs register is used to keep an accurate record of the quantities of controlled drugs. The register had been poorly completed and not maintained in line with controlled drugs regulations. Controlled drugs are prescription medicines controlled under the Misuse of Drugs legislation which require stricter controls to be applied, to prevent them from being misused, obtained illegally and causing harm.
- Medicines kept in the medicines room, medicines cupboard and fridge were stored outside the recommended temperature range. If medicines are not stored properly they may not work in the way they are intended, and so pose a potential risk to the health of the person receiving the medicine.
- Two people were self-medicating. However, they had not been risk assessed to check they were capable of using their medicines correctly.
- Two other people were prescribed medicines to be taken at night, as this was when these particular medicines worked best. However, staff were administering them at 16.00. The registered manager told us this was how they were dispensed by the pharmacist. However, staff had not taken any steps to raise this discrepancy with the pharmacist.
- Body maps used to show where creams were to be applied and where pain patches had been placed, were not completed. Staff were therefore unable to know where to apply the cream or a new patch. A pain patch should be rotated to a different area of the body each time it is changed, to reduce skin irritation.
- Quantities of medicines carried forward from the previous month were not recorded, so stock could not be accounted for.
- Medicines Administration Records (MARs) were not always accurately completed as there were missing signatures and allergies were not recorded. We could therefore not be sure people had received their medicines as prescribed.
- Medicines to be returned to the pharmacy, as they were no longer required, were not stored in a tamper-proof container. This is best practice as it ensures no one has access to them. The registered manager told us they would request one from a pharmacist.

The above concerns placed people at risk of harm. The service was therefore in breach of Regulation 12 of The Health and Social Care Act 2008, Regulated Activities Regulations 2014. Safe Care and Treatment.

Following our inspection we asked Oldham Clinical Commissioning Group (CCG) Medicines Optimisation Team to carry out a controlled drugs audit at Edge Hill. Following this, they have issued the registered manager with an action plan to complete.

We asked the provider to take steps to rectify the problems we identified and they submitted an action plan

to show us how they will do this and their timescale for completion.



# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The registered manager and the provider did not have sufficient oversight of the management of medicines. The quality assurance and monitoring system for medicines was not effective. The storage and administration of medicines was not always safe and people were put at risk of harm.
- The registered manager carried out monthly medicines audits. However, these had not identified the concerns we found during this inspection. This means the audits were not robust enough.
- The service employed an external health trainer to provide medicines training and competency assessments.
- There were always staff trained in medicines administration to give people their medicines when they needed them. This included during the night. However, although staff who gave out medicines had been trained and assessed as competent to do this, we found concerns in relation to the administration of medicines. The competency checks on staff, completed by the medicines trainer and registered manager, were not sufficiently robust.
- There was a lack of detail in care plans about the safe use of fluid thickeners. This had not been identified by the registered manager.
- The service had policies to guide staff on the safe use of medicines. However, the policy around the safe use of 'as required' (PRN) medicines, lacked detail, in particular around the safe use of PRN sedative medicines and how their use should be monitored. At the time of our inspection no one was receiving PRN sedative medicines.
- The registered manager re-ordered some PRN medicines each month, irrespective of whether they were needed or not. This made it difficult to see the correct quantities of medicines, and was wasteful. We recommend this practice is reviewed.

Failure to have adequate oversight for the administration of medicines was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

- The registered manager attended local partnership meetings with other registered managers from the area. This showed they were open to listening to others and receiving and sharing information around best practice.
- The registered manager accessed NICE (National Institute for Health and Care Excellence) guidance on medicines management to inform their practice.

- The registered manager had recently strengthened their admission procedure to ensure the service could meet people's needs fully before they were accepted by the home.

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<br><br>The provider had failed to ensure the safe storage, administration and management of medicines. |
| Regulated activity   | Regulation  |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to ensure oversight of the management of medicines.                             |