Care UK Community Partnerships Ltd

Hadrian Park

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

We carried out an unannounced comprehensive inspection of this service on 1 June, 7 July and 21 July 2016. At which two breaches of legal requirements were found. These related to proper and safe management of medicines and monitoring and improving the quality and safety of the services provided.

Following our inspection we served a warning notice against the registered provider in respect of the breach in regulation 17, good governance and stated that they must take necessary action to comply with this regulation by November 2016.

We also issued a requirement notice in respect of the breach in regulation 12, safe care and treatment. The registered provider sent us an action plan detailing how and when they would take action in order to meet this requirement notice.

We undertook a focused inspection on the 20 February 2017 to check that they had followed their plan and to confirm that they now met legal requirements.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Hadrian Park on our website at www.cqc.org.uk

Hadrian Park is a purpose built care home in Billingham. The home is registered to provide care and accommodation for up to 73 older people and people with dementia. At the time of our visit there were 66 people living at Hadrian Park.

The property was divided into three units across a ground and first floor, accessed by stairs and a lift. The Lilly unit provided residential care on the ground floor whilst the Chester unit, also on the ground floor provided care for people living with dementia. Upstairs the Poppy unit provided accommodation for those people who had greater levels of dependency.

The home had a registered manager in place. 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.

At the last inspection we found that accurate and complete records of people's medicines were not being kept and some medicines were not always administered as prescribed by the doctor.

At this inspection we found there were still a number of issues with medicine management and records.

At the last inspection we found that accidents and incidents were being recorded but an analysis of the data

to look for patterns and trends was not being undertaken.

At this inspection we found this had improved. We saw a monthly accidents and incidents analysis was done for each unit. A weekly analysis was also done for each individual and an accident and incident report produced.

At the last inspection we found that systems in place to monitor and improve the quality of the service were not effective. Issues found during the inspection had not been picked up by management audits. We also found that accurate and up to date care records were not always being kept.

At this inspection we found there were still a number of issues with the audit process. Medicine audits were not being carried out as described by the registered manager and the audits that were done had failed to identify the issues we found. Inaccurate recording on audits meant that statistics gathered from them was not correct.

We found that improvements had been made to the standard of care records and those we looked at were detailed and up to date.

At this inspection we found that some improvements had been made but people were still at risk due to medicines not being managed safely and there was an on-going breach of Regulation 12.

We also found that, although some improvement had been made to care records, people were still at risk because effective quality assurance of the service was not taking place and there was an on-going breach in Regulation 17.

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 always safe.

Medicines were not always managed safely for people and records had not been completed correctly.

Accidents and incidents were regularly analysed to look for patterns and trends.

Risk assessments described in detail the risks present and the action necessary to mitigate those risks.

Is the service well-led?

Requires Improvement

The service was not always well led.

Although there were systems in place to monitor and improve the quality of the service these were not effective. Not all of the audits were undertaken in a systematic way and they had failed to identify the issues that we found.

Accurate medicine records were not always kept and this had not been identified.

Information within care records was detailed and up to date.

Hadrian Park

Detailed findings

Background to this inspection

We carried out this 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 overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Hadrian Park on 20 February 2017. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection 1 June, 7 July and 21 July 2016 had been made. We 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 legal requirements in relation to those questions.

The inspection team consisted of one adult social care inspector and one pharmacist inspector.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and information received from the local authority who commissioned the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also reviewed the action plan sent to us by the service following the last inspection.

During our inspection we spoke with five people who used the service and two family members. We also spoke with staff, including the regional director, the registered manager, deputy manager, three care workers and two senior carers.

We undertook general observations in communal areas and reviewed relevant records. These included four people's care records, medicine records and audits.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection of Hadrian Park on 1 June, 7 July and 21 July 2016 we found that medicines, including creams and ointments, were not always administered as prescribed by the doctor. There were errors on some medicine administration records (MAR) and one of the fridges used to store medicines was faulty. Accidents and incidents were being recorded but not analysed for patterns and trends and individual risk assessments did not always provide staff with all the information they needed to keep people safe.

This was a beach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection 20 February 2017 we found that the provider had completed some of the action plan they had written to meet shortfalls in relation to the requirements of Regulation 12 described above. However, we looked at how medicines were handled and found that the arrangements were still not always safe.

Records relating to medication were not completed correctly placing people at risk of medication errors. When we checked a sample of medicines alongside the records, we found that three medicines for three people did not match up so we could not be sure if people were having their medication administered correctly. This is necessary so accurate records of medication are available and care staff can monitor when further medication would need to be ordered. For medicines with a choice of dose, the records did not always show how much medicine the person had been given at each dose.

Several people were prescribed creams and ointments. Care staff applied many of these when people first got up or went to bed. At this visit, we saw the home had a system that included a body map that described where and how these preparations should be applied by staff. We saw examples of these records; however; for some creams, there was no guidance in place and some records were still not fully completed. We also found that two people had topical preparations that were noted as discontinued on the medicine administration record (MAR) but were still being applied by staff. These records help to ensure that people's prescribed creams and ointments were used appropriately.

Two medicines for two people were not available. This meant that appropriate arrangements for ordering and obtaining people's prescribed medicines were failing, which increased the risk of harm.

We found that where medicines were prescribed to be given 'only when needed,' the individual when required guidance to inform staff about when these medicines should and should not be given, was not always available or had not been updated when the dose had changed. Whilst care staff could tell us how they would give the medicines, the information was not recorded in detail or specific to individual people. This information would help to ensure that people were given their medicines in a safe, consistent and appropriate way.

Medication kept at the home was stored safely. Appropriate checks had taken place on the storage, disposal and receipt of medication. This included daily checks carried out on the temperature of the rooms and refrigerators that stored items of medication. Staff knew the required procedures for managing controlled drugs. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. Eye drops, which have a short shelf life once, open were marked with the date of opening. This meant that the home could confirm that they were safe to use.

For a medicine that staff administered as a patch, a system was in place for recording the site of application. This is necessary because the application site needs to be rotated to prevent side effects.

We looked at the current medicines administration record for one person prescribed a medicine with a variable dose, depending on regular blood tests. Written confirmation of the current dose was kept with the person's medicines administration record (MAR) sheet. Care staff were able to check the correct dose to give. Staff had recorded that this medicine had been given correctly. Arrangements were in place for the safe administration of this medicine.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. We found that whilst a daily system of medicine checks was in place the registered manager was not always notified when discrepancies were identified so that an investigation could take place.

These findings evidenced a continued breach of Regulation 12 Heath and Social Care Act (Regulated Activities) Regulations 2014.

At our last comprehensive inspection we also found that accidents and incidents were being recorded but not analysed for patterns and trends. At the focused inspection on 20 February 2017 we found that there had been improvements in this area.

We saw a monthly accidents and incidents analysis was done for each unit. A weekly analysis was also done for each individual and an accident and incident report produced. Senior management were given copies of the report so they also had oversight of accidents and incidents at the service.

At our last comprehensive inspection we found that individual risk assessments did not always provide staff with all the information they needed to keep people safe. At the focused inspection on 20 February 2017 we found that there had been improvements in this area.

Risk assessments we looked at described in detail the risks present and the action necessary to mitigate those risks. They were regularly reviewed and up to date.

Requires Improvement

Is the service well-led?

Our findings

At our comprehensive inspection of Hadrian Park on 1 June, 7 July and 21 July 2016 we found that the systems in place to monitor and improve the quality of the service were not effective. Issues found during the inspection had not been picked up by management audits. We also found that accurate and up to date care records were not always being kept.

This was a beach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection 20 February 2017 we found that the provider had made some progress towards meeting shortfalls in relation to the requirements of Regulation 17 described above. However, we looked at how medicines audits were handled and found that the arrangements were still not always safe.

The service had a registered manager in place who had been registered with CQC since 8 September 2016. At the time of our comprehensive inspection a change of management had been in progress, however, the registered manager was present during the last inspection and had been aware since that time of the issues that were found.

At our comprehensive inspection of Hadrian Park on 1 June, 7 July and 21 July 2016 a number of issues were identified with the safe management of medicines and these issues were not being picked up by the registered provider's quality assurance systems. During this inspection we found that there were still a number of errors in this area; details of which can be found in the 'Safe' section of this report. Errors and omissions were still not being picked up by management audit of medicines and this meant that people's medicine records were not accurate or complete.

The registered manager told us medicines audits were conducted monthly by the deputy manager but that regular audits were also conducted by night staff. They explained that every night five people's medicines and the associated records were checked on each unit. These checks were in place to help identify any issues quickly in order to learn and prevent the errors happening again. However, audit records we looked at showed that there was no formal structure to the audits and this resulted in some people's medicines being audited three times in a six week period whilst others were not checked at all during this time. The registered manager signed off the audits however they had not picked up that they were not being undertaken in the way in which they described. Audits were not done every night. No checks were conducted on Poppy unit between 3 January 2017 and 31 January 2017 whilst on other nights many more than five audits were done, for example twenty audits were conducted on Lilly unit on 11 December 2016.

Those audits that were conducted were not always completed correctly. On the 18 February 2017 one audit from the Poppy unit stated that a count of boxed medicines had been done and this was marked 'count correct'. However, we found from the records we looked at that there were discrepancies with the count on this day. Thirteen audits had been done on Poppy unit on this date.

Audits carried out by the deputy manager were not always accurately completed. One audit stated that pain relief charts were in place for people however the registered manager confirmed that the service did not use pain relief charts. Similar entries were made for covert and homely medicines stating the service was compliant when in fact it should have been marked as 'not applicable' Inaccurate recording of this type meant that when the overall compliance percentage was calculated it was not correct.

Whilst the registered provider had completed some medication audits that had identified some issues, we saw evidence which highlighted effective audits of medicines were still not taking place.

These findings evidenced a continued breach of Regulation 17(1) (Good governance) of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last comprehensive inspection we found that people's care records were not always accurate or up to date. At the focused inspection on 20 February 2017 we found that there had been improvements in this area.

Care records we looked at contained detailed and current information relating to people's care needs and these were being reviewed regularly with any changes noted.

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 People who used the service were not protected against the risks of unsafe or ineffective care because medicines were not always managed correctly and medicine records were not always accurate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who used the service were not protected against the risk of inappropriate or unsafe treatment because effective systems and processes were not in place to monitor and improve the quality of the service.