Methodist Homes
Langholme
Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires improvement

Overall summary

We carried out a comprehensive inspection on 17 February 2015. A breach of the legal requirements was found. This was because the arrangements in place for the administration and management of medicines at the service were not robust. There were gaps in the medicine administration records (MAR) where staff had not signed to show they had given people their medicines at specific times of the day as prescribed. Handwritten entries on the MAR had not been signed by two people to help reduce the risk of errors. Prescribed creams were not recorded when applied by staff, and creams were not dated when opened. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

After the comprehensive inspection the registered provider wrote to us to say what they would do to meet the legal requirements in relation to the breach. As a result we undertook a focussed inspection on the 26 June 2015 to check they had followed their plan and to confirm they now met legal requirements.

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

Langholme is a care home for older people who are living with dementia. At the time of the focussed inspection on 26 June 2015 there were 36 people living at the service.

There was a registered manager in post. 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 this focussed inspection we found the registered provider had addressed some of the concerns found at the last inspection, however there continued to be concern regarding people receiving prescribed creams as prescribed and these being recorded appropriately by staff.

At the beginning of June 2015 the service had begun to use a new method of administering and managing

Summary of findings

people's medicines. The service now used a medicine dispensing system (MDS) which placed all prescribed medicines in pharmacy sealed blistered packs pre prepared with doses for each individual. This meant it was clear when prescribed medicines were due and helped ensure medicines would not be missed.

The medicines administration records (MAR) had been fully completed by staff when people had been given their medicines. There were no gaps on these records.

All handwritten entries, which had been entered on the MAR following advice and guidance from medical professionals, had been signed by two staff. This helped reduce the risk of errors.

Some people were prescribed topical medicines such as creams. The MAR was not signed by staff when the cream was applied. This meant is was not clear if people had their creams applied as prescribed. Creams were not dated upon opening, this meant staff were not aware of the period during which the cream was safe to use and when it should be discarded as expired.

One person had been prescribed a cream for a specific period of time after which the treatment should have been reviewed. The review had not taken place and the cream continued to be available in their room.

The action taken by the provider to address the concerns raised in the previous inspection had not been entirely effective. This service remains in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Summary of findings

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 entirely safe. We found some action had been taken to improve the safety of the administration of medicines at the service. However, the service could not demonstrate people always received prescribed medicines and creams as directed.

Requires improvement

Langholme

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 focussed inspection of Langholme on 26 June 2015. This inspection was completed to check that improvements had been made to meet legal requirements after our comprehensive inspection on 17 February 2015. We inspected the service against one of the five questions we ask about services; is the service safe? This is because the previous concerns were in relation to this question.

The inspection was carried out by one inspector. Before our inspection we reviewed the information we held about the home. This included the information from the service regarding what steps they would take to meet the legal requirements.

We spoke to the registered manager, the deputy manager, two people who lived at the service and two staff. We checked the records relating to the administration of medicines at the service.

Requires improvement

Is the service safe?

Our findings

At the comprehensive inspection on 17 February 2015 we found it was not clear from the Medication Administration Records (MAR) whether some people had received their prescribed medicines at the appropriate times. There were gaps in the records where staff had not signed to show they had given a person their medicines at specific times of the day. Handwritten entries on the MAR had not been signed by two people to help reduce the risk of errors. Prescribed creams were not recorded when applied by staff, and creams were not dated when opened.

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

At our focussed inspection of 26 June 2015 we found that the provider had taken some action to address these shortfalls.

Since the last inspection the service had undertaken regular audits of the medicines system. This had identified that errors were continuing to occur. Some gaps were continuing to be found in the MAR where staff had not signed the record when people had been given their medicines. This led to the service changing the system and process used. On the 1 June 2015 the service started using a medicine dispensing system (MDS) which placed all prescribed medicines in pharmacy sealed blistered packs prepared with the doses for each individual. This meant it was clear when prescribed medicines were due and helped ensure medicines would not be missed.

All staff had been provided with training on the new system. Staff told us they found it easier to use than the previous system. One staff member told us: "Its all here clearly marked so easier to see what is due and when."

People told us they received their medicines at appropriate times and they could always ask for any pain killers should they need them.

There were no gaps found on the MAR. Staff had signed the records when each person's medicines were given. We saw some handwritten entries had been added to the MAR by staff following advice and guidance from a medical professional. These handwritten entries had been signed by two people according to the policy held by the service. This helped ensure the risk of errors was reduced.

During this inspection we saw staff had clearly indicated when some people had been absent from the home or refused or not required their medicines. These medicine doses remained in the MDS and staff had used the appropriate code to show why the medicines were not given. However, we found one persons medicines remained in the MDS when the person should have been given them and staff had signed the MAR which indicated the person had received their medicines. We discussed this with the manager who told us this person had been out of the home at this time with family. This meant the staff could not have given the person their medicine. Staff had made an incorrect entry on the MAR as it should have been marked with a coded letter to indicate the person was absent from the home. This demonstrated the recording systems in place were not consistently adhered to.

Some people's medicines for the next two days had been removed from the blister packs. This meant some people did not have doses for the coming days in their packs. We asked staff and the registered manager why these medicines were missing. The missing doses were at the end of the blister pack We were told there were occasions when medicines had become 'wasted' either due to having been placed in a wet medicine pot or dropped on the floor by accident. These medicines needed to be replaced for that dose and so replacements were taken from the end of the cycle in the persons blister pack. The staff then requested replacement doses from the pharmacy which arrived in separate containers to ensure the person had sufficient stock of their medicines. Staff were not recording when this issue occurred which meant it was not clear to staff why people's medicines were not in the pack.

We checked the topical medicine (cream) administration records for 20 people. All of them contained gaps where staff should have signed to show the cream had been applied as prescribed. This meant the service could not ensure people had received their cream as directed. Creams were not dated when opened. This meant staff were not aware of the period during which the cream was safe to use and when it should be discarded as expired.

One person had been prescribed a cream for a specific period of time. This was clearly marked on the cream box in their room, on the MAR and the cream records for this person. The cream was to be reviewed on the 18 June 2015. We were shown an entry in the diary for this date which stated this person was to see the GP for this reason. We

Requires improvement

Is the service safe?

were told by the deputy manager that this review did not take place. The cream was removed from the person's room and we were told this would be reviewed immediately.

The service had not fully addressed the concerns found at the previous inspection. At this focussed inspection we found the service had taken some action to meet the requirements of the regulation by changing the system used to manage medicines at the service. However, the system had only been in use for a short while and the service was not able to ensure that people always received their prescribed medicines and creams as directed and that it was appropriately documented by staff.

The service remains in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 care and Treatment Care and treatment must be provided in a safe way for service users including the proper and safe management of medicines. Regulation 12 (1) (2) (g)