Gerald William Butcher

Earlfield Lodge

Inspection report

21-31 Trewartha Park
Weston Super Mare
BS23 2RR

Tel: 01934417934

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22 January 2018

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out a comprehensive inspection of Earlfield Lodge on 21 and 23 November 2017. Following this inspection, we served a Warning Notice for a breach of regulation 12 of the Health and Social Care Act 2008. This was because people who used the service were not protected from the proper and safe management of medicines.

We undertook a focused inspection on 22 January 2018 to check the provider was meeting the legal requirements in regards to one of the regulations they had breached and had complied with the Warning Notice. This focused inspection looked at the breach of regulation 12. This report only covers our findings in relation to this area. You can read the report from our last comprehensive by selecting the, 'All reports' link for 'Earlfield Lodge' on our website at www.cqc.org.uk

Earlfield Lodge provides accommodation and personal care for up to 65 older people, some of whom are living with dementia. At the time of our inspection the service was providing accommodation and personal care to 56 people.

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 inspection, we found the provider had taken action to comply with the warning notice. We made a recommendation about the recording of topical medicines as further improvements were required.

Medication Administration Records (MAR) were being completed consistently. A daily system was in place to identify and take action around any gaps in recording. Photographs of people, descriptions of how people preferred to take their medicines and protocols for as required medicines had been included in people's medicines records. Records were kept on why as required medicines had been administered.

Self-medication risk assessments had been completed where appropriate. The medicines policy had been reviewed and amended.

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

Improvements had been made in the administration of medicines.

We could not improve the rating for this key question from requires improvement. There are additional areas for improvement required under this key question. In addition we would require a record of consistent good practice over time. We will review our rating for safe at the next comprehensive inspection.

Earlfield Lodge

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. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Following our inspection on 21 and 23 November 2017, we served a Warning Notice for a breach of the regulation 12 of the Health and Social Care Act 2008.

We undertook a focused inspection of Earlfield Lodge on 22 January 2018. During this inspection we checked that the improvements required by the provider after our last inspection had been made. This was in relation to the safe management of medicines.

The inspection was unannounced and undertaken by one inspector. We inspected the service against one of the five questions we ask about services: is the service safe. This is because the breach found at the last inspection for which the Warning Notice was served was in relation to this question.

During our focused inspection we spoke with the registered manager, deputy manager and two staff members. We reviewed 16 people's records in regards to their medicines. This included Medication Administration Records (MAR), Topical Medication Administration Records (TMAR), care records and medicines audits.

Requires Improvement

Is the service safe?

Our findings

At our previous comprehensive inspection of Earlfield Lodge on 21 and 23 November 2017, we found that the administration of medicines was not safe. This was because Medication Administration Records (MAR) and Topical Medication Administration Records (TMAR) were not consistently completed, risk assessments for people who were self-medicating had not been completed, systems to check medicines were being administered as prescribed were not effective, protocols were not in place for as required medicines and medicine errors had not always been reported.

At this inspection, we found the provider had taken actions to comply with the warning notice. However, further improvements were required in regards to topical administration records.

11 Topical Administration Records (TMAR) we reviewed showed there were gaps in recording. This meant that there was a risk that people were not having their cream and lotions administered as prescribed. Another member of staff had recently joined the staff team to provide further support to staff in medicine administration. An audit had been completed the week prior to our inspection which identified these gaps in TMAR. However, no action had yet been taken. Gaps in TMAR were not being reported promptly so that immediate action could be taken. There was no effective system to regularly check that TMAR had been accurately completed.

Body maps were held with people's TMAR which showed where on the body cream and lotions should be applied. Written directions had not always been completed. For example, for one record we reviewed it said, 'Apply all over the body, twice daily.' However, for another record there were no written directions on where to apply on the body and how often.

We recommend that the service considers current guidance on the recording of topical medicines.

We reviewed people's MARs. Gaps in recording had significantly reduced. Where there was a gap on the MAR this had always been identified in a daily check and prompt action taken. We highlighted to the registered manager that it was not always clear what the outcome was of the action taken. The registered manager said this would be addressed.

Significant medicine errors were now being reported through the accident and incident system, this detailed the actions that had been taken. These were audited on a monthly basis by a manager.

Protocols were in place in all records we reviewed for people's as required medicines. These protocols described when a person may require the medicine and how this may be demonstrated and communicated to staff. Records were kept of why as required medicines had been administered. This enabled the service to monitor and review the effectiveness of these medicines and for any emerging patterns or trends. We found one occasion when this had not been completed.

A risk assessment was in place for one person who was self-medicating. The person had been supported by

staff in reviewing and discussing current arrangements with health professionals.

Medicines to treat acute conditions were being given as prescribed. For example, MAR for two people indicated that antibiotic had been given as prescribed.

An up to date photograph was included in people's medicines records. This contained a date of when the photograph had been taken. This enabled staff to recognise and visually check the medicines corresponded to the person.

All the records we reviewed contained a description of how people preferred to take their medicine. For example one record said, '[Name of person] tips them onto the table and likes to know what tablets they are. Taken with a glass of water.'

Regular stock checks of medicines that required storage in accordance with legal requirements were now being conducted monthly. The registered manager said the frequency of these checks would be reviewed to ensure that any actions needed would be promptly identified.

The provider's policy in regards to medicines had been reviewed and updated to reflect the current staffing provision at the service.

The registered manager had produced an action plan which included all areas of medicines administration that had been identified as needing improvements.