Embrace All Limited

Sydmar Lodge

Inspection report

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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 an unannounced focussed inspection on the 17 May 2016. This meant the staff and provider did not know we would be visiting.

Sydmar Lodge provides accommodation for up to 57 people who require support with their personal care. The service provides support for older people and people living with dementia. At this inspection, the manager informed us there were 40 people using the service during the inspection. The premise is a purpose-built care home with passenger lift access to the first and second floor.

The provider recently employed a new manager who was in the process of applying to become the registered manager for the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law. 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.

We previously visited this service for an unannounced focussed inspection on 24 August 2015. During that visit, we found that people were not protected against the risk associated with the unsafe management of medicines, which was a breach of regulations.

At this focussed inspection, we checked to see that improvements had been implemented by the service in order to address the breach of regulations. This report only covers our findings in relation to that. Reports from our last comprehensive inspections are available on our website by selecting the "all reports" link for Sydmar Lodge at www.cqc.org.uk.

At this inspection on 17 May 2016 we looked at arrangements for the management of medicines and found that improvements had been made. We reviewed the provider's action plan and saw evidence of the actions they had taken.

We looked at the management of medicines. There were concerns at the last inspection that people may not have been receiving their medicines as prescribed. We saw improvements had been made to the ordering process for repeat medicines to ensure people got their medicines on time and that regular stock checks were being carried out. We found no incidences on this inspection where people had not received their medicines as prescribed. This was an improvement in comparison with our previous visit.

We have, however, made a recommendation about the management of medicines. This is because some staff who administer medicines had not received appropriate training. There was also no documentation of regular pain assessment or the use of any pain assessment tools. This meant that people's pain may not be appropriately managed, especially for those with dementia whose medicines were prescribed as 'when required'.

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 consistently safe. Systems were in place to ensure people received their medicines safely. However, some staff who administer medicines had not received appropriate training. There was no documentation of regular pain assessment or the use of any pain assessment tools. This means that people's pain may not be appropriately managed, especially for those with dementia whose medicines were prescribed as 'when required'. We have made a recommendation about the management of medicines.

Sydmar 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. This was a planned inspection 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 this unannounced focussed inspection at Sydmar Lodge on 17 May 2016. The inspection was completed to check whether the provider had addressed the breach of regulations arising from the inspection on 24 August 2015, that people were not protected against the risks associated with the unsafe management of medicines.

We inspected the service against one of the five questions we ask about services: Is the service safe? This was because the service was not meeting legal requirements in relation to that question on our previous visit.

A Pharmacist Inspector carried out this inspection. We reviewed the information the provider had sent to us about the actions they had taken following our previous visit before carrying out the inspection. During this inspection we spoke with the manager of the home, the deputy manager and two senior care staff with responsibility for medicines. We also spoke to three people using the service, and checked the medicines records for thirty people.

Requires Improvement

Is the service safe?

Our findings

We previously visited this home on 24 August 2015 and found that it was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, for the proper and safe management of medicines. As part of this focussed inspection we checked to see that improvements had been made and action plans implemented by the service to meet legal requirements. We found that some improvements had been made.

We found no incidences on this inspection where people had not received their medicines as prescribed due to them not being available in the home. The majority of people's medicines were supplied by the same pharmacy and the number of GPs used by people had significantly reduced compared to our previous inspection. Staff told us how the ordering process had improved and we saw evidence of checks and communications with the GP and the pharmacy to ensure that all medicines were received on time. We saw deliveries from the pharmacy for next month's medicines, and staff told us how this would be booked in for the start of the next month's medicine administration record (MAR) cycle.

We saw evidence that staff carried out regular stock balance checks and medicines management audits to reduce the risk of medicine administration errors. Although we were informed of an incident where someone missed two days of antibiotic doses after returning from a hospital admission, the new manager assured us that systems were now in place to prevent this happening again.

Medicines received from pharmacy were recorded on the MAR charts and the quantity could be reconciled with the administration records which were clear and accurately documented. We checked the medicines disposal records and found these clearly detailed medicines that were returned or destroyed.

Medicines were stored safely and securely including controlled drugs (CDs - medicines which are more liable to misuse and therefore need close monitoring). Registers were in place to record the handling of CDs and we saw evidence of regular balance checks.
Fridge and room temperatures were appropriately monitored and were within the recommended range.

There was evidence that people receiving medicines that needed regular blood monitoring and dose changes were appropriately managed.

Staff told us how they rotated the sites used for administering medicines supplied in patch form. We saw the use of patch charts for people who needed a pain relief patch. This meant it was clear to staff where and when patches had been applied, and reduced the risk of harm from duplicate application. Body maps and topical MAR were also in use in the service and these detailed where creams should be applied.

Some medicines taken as needed or as required are known as 'PRN' medicines. Some people were prescribed PRN medicines for pain relief. Staff told us that PRN medicines were offered to people on a regular basis and that most people were able to communicate with them if in pain. However, we did not see any documented evidence that staff carried out regular pain assessments and there was no pain

assessment tool for staff to follow when administering these medicines especially for people with dementia. These meant that people's pain may not be appropriately managed.

Records showed that not all staff responsible for administering medicines had completed all relevant training, which senior staff at the service confirmed as correct. This had potential to undermine the safe management of people's medicines.

People who were able and wished to do so were supported to manage their own medicines following an assessment. One person told us that they were happy to be able to manage their own medicines.

We were told that no-one was receiving their medicines covertly. The manager told us that this may change in the near future because one person currently in hospital may require covert administration on discharge. We noted that the service has a policy in place to cover this.

We saw some evidence of medicines reviews carried out by people's GPs. However we did not see any documented evidence of regular or urgent review of medicine particularly for people identified to be at risk of falls. We drew this to the attention of the manager.

We recommend that the service consider current guidance on training and medication reviews, and take action to update their practice accordingly.