Coverage Care Services Limited

Coton Hill House

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

The inspection took place on 31 January 2017. The inspection team consisted of one member of the Care Quality Commission medicines team.

Coton Hill House is registered to provide accommodation with personal care to a maximum of 45 people. Some people using the service were living with dementia.

There was a registered manager at this service however, they were not present on the day our inspection. 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.

Where people were prescribed medicines on a when required basis there was insufficient information to show care staff how and when to administer these medicines or the responses to treatment they should observe. Staff did not consistently check with the prescriber the accuracy of people's medicines when they moved into the home. People's medicines were stored safely and securely. There were processes in place for handling medicines errors and staff received medicine competency assessments to ensure the on-going safe management of medicines.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

The service was not consistently safe.

Where people required medicine as required there was insufficient information to guide staff when this was to be given or the responses to treatment they should observe.

Staff did not consistently check the accuracy of people's medicines with the prescriber.

Staff received competency assessments to ensure the on-going safe management of medicines.

Medicines were stored safely and securely.

Coton Hill House

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 this focused inspection to establish if the provider had systems in place for the safe management of medicines. This report only covers our findings in relation to the management of medicines. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Coton Hill House on our website at www.cqc.org.uk.

During our inspection we spoke with three staff which included the acting manager, the deputy manager and a care staff member. We looked at the electronic Medicine Administration Records.(eMAR) charts for nine people. We also looked at the care plans and care records for five people.

Inspected but not rated

Is the service safe?

Our findings

A member of the CQC medicines team reviewed the management of medicines; including the electronic Medicine Administration Record (eMAR) charts for nine people and the care plans and care notes for five people. People were living in five different units within the home and this sample covered all units. The home used the eMAR system for recording the receipt and administration of medicines. Care plans were held in paper format. Both systems held photographs of residents to aid identification and allergy information to reduce the risk of inappropriate medicines being provided.

Medicines were stored safely and securely within the home, including medicines requiring refrigeration. Medicines with a short expiry when opened were dated to ensure staff would be aware when these were no longer suitable to be used. Controlled drugs (which are medicines that require extra records and special storage arrangements because of their potential for misuse) were stored and recorded in line with regulations.

Some people were prescribed medicines on a when required basis. We found that people's records had insufficient information to show care staff how and when to administer these medicines or the responses to treatment they should observe. This meant that people may not have received their medicine in a consistent way and when it was needed. We saw that when these medicines had been used care staff were recording the reasons for use and whether or not they had been effective on the electronic record. However, there was no information on the eMAR or within care plans to describe actions to take if an intended outcome from when required treatments was not observed.

Some people had medicines given via a skin patch, although staff were able to describe the correct process for selecting a suitable site of application there were insufficient records to show this was being done safely.

Some people were receiving medicines via a topically applied cream or ointment. We saw that the home used topical administration charts to ensure care staff were aware of where and how often to apply the cream and records of application were being kept.

We tracked the arrival of two new people into the home to determine whether the processes involved in obtaining medicines information about new residents kept them safe. We saw that, for one person admitted the day before the inspection, steps had been taken to confirm medicine use with the GP and conflicting information was questioned before the resident received medicines. For a second person admitted in November 2016 we did not see evidence that the medicines received into the home on admission were checked for accuracy against a second data source. We were told that the ward discharge letter had been received but could not be found. We also saw that the process for checking medicines on admission to the home had altered since this admission.

We spoke to the interim manager, the deputy manager and a member of care staff about the process for handling medicine errors. We saw that the home's policy was being followed and competency assessments for medicine administration tasks were in place to keep people safe.

We asked the deputy manager how visiting clinicians were alerted to a person's current medicine list and we were told that in all circumstances clinicians would be able to view medicines. We were told that a print out of the electronic MAR sheet would be provided to doctors who did not attend from people's own surgery. Staff told us, when the persons own GP attended the care staff would cross check the summary information they brought with them against the electronically held medicines list.

Where variable doses were prescribed we saw that the electronic administration record detailed how much medicine had been given to a person on each occasion.

We saw that stock checks of medicines had identified discrepancies because of how refused medicines were recorded. The management had highlighted this issue to staff and stock discrepancies had reduced through improved recording. We were told that senior carers examined the electronic administration records at the end of each shift to identify any gaps and ensure concerns could be dealt with in a timely fashion. We did not see unexplained gaps on the eMAR records for any of the people whose records we examined.