MAPS Properties Limited

Nightingale Care Home

Inspection report

Church Lane
Welborne
Dereham
Norfolk
NR20 3LQ

Tel: 01362850329
Website: www.norfolkcarehomes.co.uk

Date of inspection visit:
11 July 2017

Date of publication:
11 October 2017

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 16 March 2017.After that inspection we were informed about a serious incident relating to the unsafe management of medicines. We had additional concerns as the provider had failed to notify us of the incident, which they are required to do. This incident had placed people at risk of harm and we wanted to make sure that unsafe practice had not continued. We therefore decided to carry out a focussed inspection, which only reviewed this aspect of the service. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Nightingale Care Home on our website at www.cqc.org.uk

This inspection took place on 11 July 2017 and was unannounced.

The service provides accommodation for up to 47 people, some of whom are living with dementia.

A registered manager was 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.

This report specifically focuses on the key areas of Safe and Well-Led with regard to how medicines were managed at the service. This included a consideration of the safe ordering, storage, administration, stocktaking, disposal and auditing of medicines.

We had been alerted to an incident where, on the advice of a healthcare professional, one person's controlled drugs had been given to another person. This was not in line with the provider's own medication policy. This incident had placed the person at risk of harm and prompted our responsive inspection. At this inspection we concluded that, although some recent improvements in the administration of medicines had taken place, not all medicines were managed safely. In addition we were concerned that a full investigation into this incident had not taken place and lessons learned.

Staff managed people's regular medicines well and people received their medicines at the correct times. Although medicines were made available to people promptly when newly prescribed, information on some medicines was not available to guide staff. Staff were not clear about how to administer one emergency medicine and had not received the required training.

Medicines were stored appropriately but some recording of the room temperature was missing. This meant we could not be assured that medicines were always stored in a way which ensured they were safe and effective to use. Medicine trollies and the medicine room were well organised.

Drugs stored in the controlled drugs cupboard were mostly well managed but stocks for one medicine did not tally with records. This meant there was a risk that a person had not received the correct dose of their

medicine. One medicine had not been administered according to the manufacturer's instructions which placed the person at risk of harm.

Audits had not identified the errors we found. Some audits could not be located and the registered manager did not have clear oversight of all the issues related to the safe management of medicines. Where errors had taken place, these had not been fully investigated by the registered manager or provider or notified to the Care Quality Commission or the local authority as a safeguarding matter.

We found a breach of regulation related to the management of medicines. You can see the action we took at the back of this report.

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.

Medication administration systems placed people at risk of harm.

Staff administered regular medicines safely but medicines required for occasional use were not always well managed.

Staff had not received all the training they needed to administer medicines safely.

Systems designed to monitor the administration of medicines failed to identify errors which could put people at risk.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager did not have clear oversight of the administration of medicines. Staff had not been provided with the medicines training they needed.

Audits, although comprehensive, were not always effective in addressing issues they identified. Some audits failed to identify significant discrepancies in stocks of controlled drugs.

The registered manager had not carried out a full investigation into a recent incident where medicines were not managed safely

Nightingale Care Home

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.

The inspection took place on 11 July 2017 and was unannounced. It was completed by one inspector and was a focussed inspection in response to an incident where medicines were not managed safely.

Before we carried out our inspection we reviewed the information we held about the service. This included the information of concern we had about an incident of poor administration of medicines at the service. We also looked at any statutory notifications that had been sent to us. A notification is information about important events which the service is required to send us by law.

We spoke with one person who used the service, three senior care staff with responsibility for administering medicines and the registered manager.

We reviewed sixteen records relating to people's medicines and records regarding the auditing of medicines.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 16 March 2017 we rated this key area as Good. During this current inspection we reviewed the procedures for the ordering, storage, administration, stocktaking and safe disposal of medicines to establish if systems remained safe. We found both good and poor practice with regard to the management of medicines.

The temperature of the medication room was recorded and monitored to ensure that medicines were not exposed to extreme temperatures, which might mean they could become unsafe or not work so well. However, we noted that recording was not consistent. For example, staff had not recorded the temperature on 6, 7 or 8 July 2017 or on five occasions in June 2017. This meant that we could not be sure that medicines were always stored correctly. We found that most medicines were dated when opened and none was being used beyond the date which was considered safe. However, we did identify that one bottle had not been dated.

We audited the controlled drugs record book, the stocks of the controlled drugs cupboard and the medication administration record (MAR) charts to check that people had received these medicines correctly. We had concerns about the stocktaking, administration and auditing of two medicines in the controlled drugs cupboard.

We found that the dosage of one medicine stated that 3mls should be given three times a day. However the MAR chart and health notes stated that, following a recent change, this should be 4mls four times a day, with two more 4ml doses as required. This contradiction could be confusing for staff. We checked the stock of this medicine and found records did not tally. The total amount of medicine recorded in the controlled drugs register was 626.5mls. However, we could easily identify that this was incorrect as there were only two 300ml bottles in stock and one had been opened and several doses administered. Staff were unable to give us an explanation for this discrepancy. We identified that a series of errors had taken place calculating the remaining stock. Two staff carried out a daily audit of the controlled drugs cupboard. The most recent audit, signed on the morning of 11 July 2017,had not identified any issue and stated, 'all controlled drugs are correct'. We could not be assured that this person had received the correct amount of this medicine.

We found that a second medicine for this person had not been given in accordance with the prescriber's instructions. The person was supposed to have a new morphine patch, a controlled drug, every three days. We saw that on one occasion the person had not had a new patch for four days. This meant there was a risk that the person's pain was not as well controlled as it should have been. We also found that patches were not being correctly positioned on people. The manufacturer's instructions stated that a patch should not be replaced in the same spot for three to four weeks. However, we saw that the same place was used every other week. This risked a breakdown in the person's skin and also risked the medicine being less effective.

Records for medicines which were not controlled drugs were accurate. These included those for Warfarin which needs to be carefully managed and monitored. Stocks recorded in the MAR charts tallied correctly with those we found. MAR charts were completed each time a medicine was administered and we found no

gaps. However, staff did not consistently record the administration of creams on the MAR charts. One chart had only been completed 12 times in the last three months. Another chart stated, 'See Topical MAR in room' but a senior staff member told us that the person did not have a chart in their room. This meant we could not be assured that people were receiving their topical creams as prescribed.

We found medicines which were only given occasionally or were only recently prescribed were not always well managed. For example, buccal midazolam had recently been prescribed for one person and was already prescribed for a second person. There was limited information about how and when to administer this medicine and no protocols to guide staff. This medicine can be used in the event of a person having an epileptic seizure and is administered between the cheek and the gum via a syringe. The MAR chart contained a handwritten instruction for the most recent prescription saying, 'Give one dose if fit is prolonged'. This did not give staff sufficient information about how and when to give the medicine. It did not clarify what 'prolonged' meant. One senior staff member said, "It's if [they have] a fit for more than four minutes" but this information was not recorded anywhere and it was not clear what this understanding was based on.

The MAR chart for the second person recorded, , 'Insert into mouth in case of fit'. This lack of clear information and of protocols meant there was a risk that people would not receive the prescribed medicine correctly and promptly. Senior staff , who were the only staff who administered medicines, were not clear about how to give this medicine. They confirmed that although they had received training in administering medicines, they had not received training regarding this particular medicine. Following our inspection the registered manager confirmed to us that some staff had now undergone this training and other sessions were planned. However, at the time of our inspection staff were not trained and the registered manager had not identified this lack of training as a potential risk.

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

We found that systems for ordering medicines each month were clear and the service ensured people's regular medicines were in stock. For example, one person had seen a GP the previous day and had antibiotics prescribed. We saw that this medicine had been promptly collected and made available to the person who used the service.

There were appropriate storage facilities for medicines, including controlled drugs. Controlled drugs were securely stored in a suitable cabinet. Medicines such as oromorph and midazolam were also stored in the controlled drugs cupboard and recorded in the controlled drugs register. This is not a requirement for these particular medicines but is good practice. Staff had recently reorganised the medicine trollies. These were clearly marked and tidy, which made it easy for staff to locate the correct medicine and corresponding record.

Information about people's medicines was available to guide staff. There were good profiles informing staff what each person's regular medicines were for and how they liked to take them. Staff knowledge, with regard to people's regular medicines was good. Although nobody had their medicines hidden in food or drink, the staff understood the procedures that had to be put in place before this could be arranged. Time sensitive medicines, such as those for people with Parkinson's disease, were given in accordance with the prescriber's instructions.

We found that there was an appropriate stock disposal procedure in place and staff clearly recorded items for disposal in a returns book. Items were stored safely while waiting to be returned to the pharmacy and

safely disposed of.

Staff carried out daily audits of the controlled drugs and one staff member had a delegated task to audit all the medication each month. The registered manager was unable to locate all the recent medication audits. The most recent audit which could be located was dated 23 January 2017. In addition to this two external organisations had carried out medication audits in recent months and had produced reports. We noted that some new systems and improvements to paperwork had been put in place following these audits. However, the most recent external audit, dated 30 May 2017, had identified some of the issues we found, such as failing to record the room temperature, failing to record the administration of creams correctly and failing to have PRN protocols for some medicines. This meant that the service had not responded to the issues raised in May 2017. We concluded that the quality of the service's audits was not sufficiently robust as they failed to identify the issues we found. In addition the service failed to act on concerns identified by the external audit. This meant unsafe practice was able to continue placing people at potential risk of harm.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in March 2017 we found that the service was Well-Led and this key area was rated Good. The current inspection was only undertaken to review medication procedures. We also wished to ensure that lessons had been learned from the recent incident where controlled drugs had not been safely managed.

Although medication administration procedures had been reviewed and audits undertaken we found that the administration of some medicines continued to place people at potential risk of harm. We were concerned that the registered manager had not taken timely action to ensure that lessons had been learned from the incident which prompted our inspection.

We noted that there had been no recorded communication with staff or staff meeting to discuss what had happened and no clear guidance issued to staff so that they would know what to do if a similar incident occurred in the future. The registered manager planned to hold a meeting with staff on 30 August 2017 but this had been cancelled. To date there still has been no meeting. A letter was sent to staff on 28 August 2017 giving some basic guidance but this was several months after the original incident. This demonstrated a lack of strategy on the registered manager's part. We were not assured they had done everything they could have done to ensure medicines were managed safely in future.

We found a lack of strategy and no clear accountability with regard to the monitoring of medicines administration. Although the registered manager told us that a staff member carried out regular medicines audits, we were not able to see these as that staff member had locked them away and the registered manager, who is the legally responsible person, did not have a key. This demonstrated a lack of oversight on the registered manager's behalf.

We asked if the staff member randomly sampled people's medicines to check stocks and records. The manager was not able to confirm if this was the case. We located the audit from January 2017 and found it was comprehensive but had clearly identified areas which needed to improve. The registered manager was not able to tell us which of these issues had been addressed. Although this responsibility had been delegated to another staff member, the ultimate responsibility remained with the registered manager.

We also saw an audit carried out by the operations manager on 21 February 2017. This identified that a notification of a medication error should be sent to CQC but this did not take place. The registered manager had also failed to notify CQC of the incident which prompted our inspection. This issue was raised after an external agency had been brought in to audit medicines administration. They identified the issue and advised the provider to make the appropriate referrals to the local authority safeguarding team who then notified CQC.

We had concerns about the quality of the medication audits the service carried out. We concluded that these had not been robust as some of the issues we identified during this inspection dated back several weeks. The service's own audits and external audits identified issues but action was not always taken to

address them. The registered manager did not have an effective system to review the quality of the audits.

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 The provider failed to ensure the proper and safe management of medicines. Regulation 12 (1) (2) (g).