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Meadowview Nursing Home

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 inspected Meadowview Nursing Home on 17 May 2016. The service provides accommodation with nursing and personal care for up to 42 people. At the time of our inspection there were 22 people using 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.

We carried out an unannounced comprehensive inspection of this service on 27 January 2016. We found the provider was not meeting the legal requirements of two of the fundamental standards. After the comprehensive inspection, we took enforcement action and issued a warning notice to require the provider to meet the legal
requirements of one of the fundamental standards. This inspection in May 2016 was to check they had met the legal requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which relates to people's safe care and treatment. This report covers our findings in relation to this requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Meadowview Nursing Home on our website at www.cqc.org.uk

Since January 2016 the provider had improved the system for the management of medicines. Staff administering medicines signed Medicine Administration Records (MAR) after medicines were administered. There were protocols in place to support people with specific requirements related to medicines and these were followed. However there were still improvements needed as handwritten entries on MAR were not always dated. There were not always protocols for medicines prescribed 'as required'.

People's care plans contained detailed risk assessments and where risks were identified there were management plans in place to mitigate the risk. However, risk assessments in relation to stair gates did not identify why they were in place or any risks to people for the stair gates being used.

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.

Medicines were administered in a safe and respectful way.

Entries on Medicine Administration Records (MAR) were not always dated.

Risk assessments had been completed and management plans were in place.

Risks associated with stair gates had not been fully assessed and recorded.

We have improved the rating for this key question from inadequate to requires improvement. We will check for further improvement at our next planned comprehensive inspection.

Meadowview Nursing 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 checked whether the provider
was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook an unannounced focused inspection on 17 May 2016. At the time of our visit there were 22 people living at Meadowview Nursing Home. This inspection was carried out to check improvements had been made by the provider after our comprehensive inspection on the 27 January 2016. This inspection looked at one of the key questions we ask about services: is the service safe. This was because the service was not meeting all of its legal requirements at the January 2016 inspection.

This inspection was undertaken by one inspector and a pharmacy inspector. We looked at seven people's records and 12 people's medicines charts. We spoke to two staff. We looked at the systems in place for managing and administering medicines.

Requires Improvement

Is the service safe?

Our findings

At our inspection in January 2016 we found care and treatment was not provided in a safe way for people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action advising the provider they must make improvements to meet the legal requirements by 29 March 2016.

At the inspection in January we found medicines were not always managed safely and records relating to the administration of medicines were not always completed. At this inspection we found improvements had been made in the handling of medicines, however further improvements were needed to make sure that people's medicines were always managed safely.

We saw medicines being administered on the morning and lunchtime medicine round in a safe and respectful way. Medicine Administration Records (MAR) were signed after people's medicines had been administered. Where people did not receive their prescribed medicines the appropriate code was entered on the person's MAR to identify why the person's medicine had not been administered.

Where people were prescribed medicines to be given 'when required' protocols were in place to give staff additional information to help them give medicines in a safe and consistent way. However, these protocols were missing for two people's medicines. Staff were able to describe when they would give people these medicines. Staff told us they would review the records immediately. It was clear when 'as required' medicines were to be administered and we were satisfied that people received these medicines when they needed them.

The pharmacy provided printed MAR for staff to complete when they administered people's medicines. Medicines were prescribed on the MAR in line with national guidelines and any relevant protocols were attached. For example, one person had diabetes. The nurse administering medicines reviewed the person and followed the protocol for the person's medicine. We saw some information attached to people's MAR and in their care plans describing how they liked to be supported to take their medicines and also advice on crushing medicines. However, where handwritten entries had been made on MAR, entries had not always been dated.

At our inspection in January 2016, we found people's care plans did not always contain completed or up to date risk assessments and risk management plans. At this inspection we found improvements had been made. People's care plans contained risk assessments and where risks were identified there were plans in place to manage the risk. For example, one person was diagnosed with epilepsy. The person's care plan detailed what action staff should take if the person experienced an epileptic episode and the support the person would need. However, we found further improvements were required to ensure risks were managed.

We saw that 12 people had stair gates across the doorway to their rooms. We looked at care plans for four of these people. Risk assessments were in place, however there was no information as to why the stair gates were necessary or any potential risks to people of the stair gates being in place. We spoke to the registered

manager and deputy manager who told us the stair gates were to prevent people from entering other people's rooms without the person's permission. The stair gates were not to prevent people leaving their rooms. Where stair gates were in place and people remained in their rooms these people were not independently mobile. We saw one person who was able to open the stair gate to enter and leave their room unaided. The person had requested the stair gate as they did not like other people entering their room and 'touching their things'.

Where people displayed behaviour which may be seen as challenging to themselves or others, risk assessments were in place. Care plans identified strategies to support the person and keep them and others safe. We saw staff supporting people in line with their care plans. When people experienced these behaviours records were completed to identify potential triggers.