Nugent Care

Margaret Roper House

Inspection report

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20 April 2016
10 May 2016

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Ratings

Overall rating for this service	Good
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 5 November 2015 when one breach of a legal requirement was found. The breach of regulation was the provider did not always ensure the safe management of medicines.

We asked the provider to take action to address these concerns. After the comprehensive inspection, the provider wrote to us to tell us what they would do to meet legal requirements in relation to the breach. We undertook a focused inspection on 20 April 2016 and 10 May 2016 to check they now met legal requirements.

This report only covers our findings in relation to this breach specific area / breaches of regulation. This is within the 'Safe' domain. The other domains 'Effective', 'Caring', 'Responsive' and 'Well led' were not assessed at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Margaret Roper House on our website at www.cqc.org.uk.

Margaret Roper House is a nursing home registered to accommodate people who have mental health care needs. The accommodation is registered for 23 people. At the time of the inspection the home had 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 and associated Regulations about how the service is run.'

At this inspection we found that the service was still in breach of the safe management of medicines. This was because medicines were not being given as prescribed, it was difficult to see how much medication was present in the home and there was a lack of guidance and care plans for a number of medicines to be given 'when required'.

You can see what action we told the provider to take at the back of the full version 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 in respect of medicines

We found that people were not protected against the risks associated with medicines because the provider's arrangements to manage medicines were not consistently followed.

Margaret Roper 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 on 20 April 2016 and 10 May 2016. The inspection was completed to check that improvements to meet a legal requirement identified after our comprehensive inspection on 5 November 2016 had been made. We inspected the service against one specific area of one of the five questions we ask about services; Is the service safe? This is because the service was not meeting a legal requirement in relation to one question.

The inspection was undertaken by an adult social care pharmacist inspector. Before our inspection we reviewed the information we held about the care home and reviewed the provider's action plan, which aims to set out the action they would take to meet legal requirements.

At the visit to the care home we spoke with the registered manager, deputy manager and a registered mental health nurse. We looked at medicine charts to ensure the safe management of medicines. The registered manager sent us copies of the medicine audits following our inspection.

Requires Improvement

Is the service safe?

Our findings

We had previously visited this home in November 2015 and found the home to be in breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action to address these concerns. After the comprehensive inspection, the provider wrote to us to tell us what they would do to meet legal requirements in relation to the breach.

At the previous visit quantities of medicines were not always carried forward from the previous month. The use of creams, ointments and other external products had not always been recorded and it was not possible to see from the records whether these products had been used as prescribed. Medicines that had been stopped by the doctor were still on the trolley, which increased the risk of a person being given the medicine incorrectly. Some people were prescribed medicines such as painkillers, laxatives and creams that were to be used only 'when required', yet there was no guidance or care plans in place to inform staff when these medicines should be used.

During this inspection there were 22 people living in the home and we checked the medicines and records for 10 people. We spoke with the registered manager, deputy manager and a registered mental health nurse.

Quantities of medicines were not always carried forward on the Medicines Administration Record Sheet (MARS) which made it difficult to tell how much medication should have been present in the home. Creams, ointments and other external products were still not always recorded. One person was prescribed three different types of creams to reduce inflammation. One of the creams should have been applied three to four times a day, however there were only daily applications recorded. The MARS for the second cream had been ticked to say it had been applied, yet there were no signatures from the person who had applied it. The third cream had been discontinued by the doctor; however it was in the medicines trolley and had not been crossed off from the MARS.

A second person was prescribed a cream to help with a skin condition. The cream was not on the MARS the following month after it had been started, and it was unclear whether this had been discontinued or missed in error. A third person who was prescribed a medicine to replace hormones had not been given the medicine for three weeks as the home had thought it had been discontinued, however it had not.

Four people were prescribed medicines such as painkillers, laxatives and creams that were to be used only 'when required', yet there was still no guidance or care plans in place to inform staff when these medicines should be used.

This is a continued breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found that people were not protected against the risks associated with medicines because the provider's arrangements to manage medicines were not consistently followed.

The enforcement action we took:

We issued a Warning Notice