Swinton Hall Nursing Home Limited

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Inspection report

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12 July 2016

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Ratings

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection in January 2016. We found medicines were not handled safely, which was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment in respect of medication. We told the provider they must take action to ensure people were protected against the risks associated with the unsafe handling of medicines. We then carried out a focussed inspection in April 2016 to check to see if improvements had been made in order to meet legal requirements and to ensure people were safe. We found that medicines were still not being handled safely and people were at risk of harm. Following that inspection we sent the provider a Warning Notice to tell them they must make improvements to ensure people were safe.

Swinton Hall Nursing Home is a privately owned nursing home close to the A580, East Lancashire Road and is within easy access to the cities of Salford and Manchester. The home is registered to provide accommodation with personal and nursing care for up to 62 people across two units. The home comprises of a 15 bed continuing care unit to support people with complex nursing needs and a nursing unit.

There was no registered manager in place at the time of our inspection, however a manager had been appointed and was in the process of applying to register with the Care Quality Commission. 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; as does the provider.

As part of this focused inspection we checked to see that improvements had been implemented by the service in order to meet legal requirements. This report only covers our findings in relation to those requirements. You can read the reports from our last comprehensive and focused inspections, by selecting the 'all reports' link for Swinton Hall Nursing Home on our website at www.cqc.org.uk.

We found limited improvements had been made had been made since our last inspection, however people were still not protected against the risk of unsafe medicine handling. We looked at medicines and records about medicines for 14 people and found there were concerns about the safe handling of medicines for all 14 people.

The systems for ordering medicines were poor and people did not have their medication delivered in a timely manner. Four people ran out of some of their medication, because it did not arrive in time for the start of the new medication cycle. One person had to wait four days for their eye infection to be treated, because the medication did not arrive when expected and nurses failed to chase the missing medication up. We also found that nurses failed to act or follow up on other health care professionals' advice regarding medication, which placed people's health at risk of harm.

We found that people who needed to have their medicines given by means of a special feeding tube were placed at risk because their medicines were not given safely.

We found as at the last inspections, that the information to guide nurses and care staff on how to apply creams and thicken fluids or give medicines prescribed as 'when required' were either missing or provided limited guidance.

We found the records about the administration of medicines and creams were still inaccurate or not in place and still could not be relied upon to demonstrate people were given their medicines safely.

We found the records about the stock of medicines in the home were still inaccurate. This meant that audits and checks could not be done to ensure that medicines had been given as prescribed.

People who were prescribed insulin must have their blood sugars monitored. We saw there was very clear guidance about what to do if one person's blood sugar levels fell outside their safe range. However, we saw that the nurses failed to follow this guidance which placed people at risk of harm.

As at the previous inspection we saw the storage of medicines was not safe. We found that creams were still not stored safely because they were not locked up in people's bedrooms.

We saw there was out of date medication in the fridge.

We found that no improvements had been made in the storage of waste medication it was still stored in open containers on the floor of the medication room, which is against national guidance.

This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, because the service had not protected people against the risks associated with the unsafe management of medication.

CQC are currently considering their enforcement options in respect of these continuing concerns.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

We found that action had not been taken to ensure people were protected from the risks associated with the safe management of medication.

We looked at medicines and records of medicines for 14 people who used the service and found there were concerns about the safe handling of medicines for all 14 people.

The systems for ordering medicines were poor and people did not have their medication delivered in a timely manner. Four people ran out of some of their medication, because it did not arrive in time for the start of the new medication cycle.

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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 an unannounced focused inspection at Swinton Hall Nursing Home on the 12 July 2016. This inspection was undertaken to ensure improvements that were required to meet legal requirements had been implemented by the service following our last inspection on 28 April 2016.

We inspected the service against one of the five questions we ask about services during an inspection, which were not meeting legal requirements, namely 'Is the service Safe.'

The inspection was undertaken by one adult social care inspector and a CQC pharmacist inspector. Before the inspection, we reviewed all the information we held about the home, including concerns that we had received. We reviewed statutory notifications and safeguarding referrals.

We also reviewed the action taken by the provider following our previous inspection, who wrote to us explaining what action the service had taken to meet legal requirements.

As part of the inspection, we spoke with the home manager, the Operations Manager and three nurses.

Inadequate

Is the service safe?

Our findings

We carried out an unannounced comprehensive inspection in January 2016. We found that medicines were not handled safely, which was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment in respect of medication. We told the provider they must take action to ensure people were protected against the risks associated with the unsafe handling of medicines. We carried out a focussed inspection in April 2016 to check to see if improvements had been made in order to meet legal requirements and to ensure people were safe. We found that medicines were still not being handled safely and people were at risk of harm. Following that inspection we sent the provider a Warning Notice to tell them they must make improvements to ensure people were safe.

On 12 July 2016, we carried out another focussed inspection to check if improvements had been made to meet their legal requirements and to ensure people were given their medicines safely. A CQC pharmacist inspector found that limited improvements had been made, however people were still not protected against the risk of unsafe medicine handling and the home was still in breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at medicines and records about medicines for 14 people who used the service and found there were concerns about the safe handling of medicines for all 14 people. The systems for ordering medicines were poor and people did not have their medication delivered in a timely manner. Four people ran out of some of their medication, because it did not arrive in time for the start of the new medication cycle. One person had to wait four days for their eye infection to be treated, because the medication did not arrive when expected and nurses failed to chase the missing medication up. We also found that nurses failed to act or follow up on other health care professionals' advice regarding medication, which placed people's health at risk of harm.

We found people who needed to have their medicines given by means of a special feeding tube were placed at risk, because their medicines were not given safely. The knowledge of the nurse on duty of how to give medication safely to people with feeding tubes was very poor and this put people at risk of harm.

We found as at the last inspections, that the information to guide nurses and care staff on how to apply creams and thicken fluids or give medicines prescribed as 'when required' were either missing or provided limited guidance. We found the records about the administration of medicines and creams were still inaccurate or not in place and still could not be relied upon to demonstrate people were given their medicines safely.

We found the records about the stock of medicines in the home were still inaccurate. This meant that audits and checks could not be done to ensure that medicines had been given as prescribed.

People who were prescribed insulin must have their blood sugars monitored. We saw there was very clear guidance about what to do if one person's blood sugar levels fell outside their safe range. However, we saw that the nurses failed to follow this guidance, which placed people at risk of harm.

As at the previous inspection we saw the storage of medicines was not safe. We found that creams were still not stored safely, because they were not locked up in people's bedrooms. We found that the nurse on duty had not improved the way they transported medicines round the home and saw that they took unlabelled medication out of the medication room and did not take the supporting documentation, which could lead to the wrong person being given medication.

We saw there was out of date medication in the fridge.

We found that no improvements had been made in the storage of waste medication as it was still stored in open containers on the floor of the medication room, which is against national guidance. We also saw that the medication room could be entered by means of a key pad code, which meant that anyone with the code to the room had access to the unwanted medication, which could be misused.

This was in breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, because the service had not protected people against the risks associated with the unsafe management of medication

We are currently considering our enforcement options in respect of these concerns.