Mrs Eileen O'Neill & Mr Brian J O'Neill

Northwood Nursing & Residential Care

Inspection report

206 Preston New Road
Blackburn
BB2 6PN
Tel: 01254 57208

Date of inspection visit: 14 January 2016
Date of publication: 16/03/2016

Ratings

Is the service safe?	Requires improvement

Overall summary

This was an unannounced inspection which took place on 14 January 2016. The service was last inspected on 4 September 2015 when we undertook a focused inspection to see if the provider had taken action against a requirement notice that had been issued. This was because people were not protected from the risks associated with the unsafe management of medicines. We found the required improvements had not been made and issued the provider with a warning notice.

This inspection was carried out to check that the provider had met the requirements of the warning notice regarding the management of medicines. We found the necessary improvements had not been made. This meant there was a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of this report.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Northwood Nursing & Residential Care' on our website at www.cqc.org.uk.

Northwood is registered to provide accommodation for up to 27 older people who require support with nursing or personal care needs. At the time of our inspection there were 26 people using the service.

The service had a registered manager in place. 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. The registered manager was supported in the day to day running of the service by a care manager.

The provider had made some improvements to the management of medicines in the service including the

Summary of findings

recording of when prescribed creams had been administered. The provider had introduced a system to assess the competence of staff to administer medicines safely. Medication audits had also been completed on a regular basis although they had not been sufficiently robust to identify the shortfalls we found during the inspection.

We found concerns regarding the way medicines were administered in the service. Medication care plans did not always provide sufficient information for staff about how medicines should be given to people who used the service. We observed staff did not follow the home's policy or good practice guidance regarding the safe administration of medicines. The stock of medicines held in the service was also not well controlled.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe. This was because required improvements had not been made to ensure people were protected from the risks associated with the unsafe management of medicines.

Requires improvement

Northwood Nursing & Residential Care

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 inspected the service against one of the five questions we ask about services: is the service safe? This was because the service was not meeting legal requirements in relation to that question.

We undertook an unannounced focused inspection of Northwood on 14 January 2016. This inspection was completed to check whether the provider had met the requirements of the warning notice which was issued following the focused inspection in September 2015. The warning notice was issued as people were not protected against the risks associated with the unsafe management of medicines.

The inspection was undertaken by an adult social care inspector and two pharmacist inspectors.

During the inspection we looked at the medication administration record (MAR) charts for 11 people who used the service. We spoke with the registered manager, the care manager and the member of nursing staff responsible for the administration of medicines on the day of the inspection. We also spoke with four people who used the service to check if they received their medicines as prescribed.

Requires improvement

Is the service safe?

Our findings

We looked at the systems in place for medicines management. We assessed the medicines administration records (MARs) for 11 out of the 26 people in the home and looked at storage, handling and stock requirements.

Medicines were stored securely in a locked treatment room. Access was restricted to authorised staff and the room was clean and tidy. In the clinic room we observed multiple unlabelled cups that contained medicines. This is a process called secondary dispensing which is not considered safe practice. The nurse on duty confirmed these were medicines prepared by them earlier in the morning to save time and this was their usual practice. We discussed this with the care manager to raise concerns about this practice and were told this should not be happening.

We observed that medicines in the Monitored Dosage System (MDS) were all given at the same time when there were medicines with differing administration instructions. For example medicine that should be given after food being given at the same time as one that should be given 30-60 minutes before food. This increases the risk of harm from side effects of mediation and may mean some medicines will not work as effectively.

We had concerns about the practice of administering medicines throughout our visit. We were concerned about the contemporaneous recording of administered medicines. We observed the nurse on duty to be signing multiple MARs at the same time after returning from administering medicines in people's rooms. This practice is not in line with the home's medicines policy or national guidance.

We looked at the MARs for all the people in the service were prescribed creams. We found the MARs provided clear instructions for staff to follow to ensure creams were administered as prescribed. All the MARs were fully completed.

Controlled drugs were stored in a controlled drugs cupboard. Access to them was restricted, and the keys held securely. There were appropriate arrangements in place for the management of controlled drugs although some documentation required verbal clarification for confirmation.

Medicines that required cold storage were kept in a fridge in the medicines clinic room. Recording of maximum and minimum temperatures was not as recommended in national guidance. On the day of our visit, the thermometer was checked and showed maximum and minimum temperatures outside the recommended range. We spoke with staff and they were unaware of this.

We found not all people had a medicines support plan in place to advise staff administering medicines how each individual liked to take them. However, where these were available, they were clear, comprehensive and person centred. We saw monitoring was carried out and documented clearly if necessary prior to administration of medicines.

We found a lack of information to guide staff how to safely administer 'as required' medicines. The recording of the exact dose given was not always documented when a variable dose had been prescribed. One resident had an unsafe dosage interval documented on their handwritten MAR for paracetamol. This was not in accordance with the prescriber's direction or the medicines care plan for the person.

Medicines were not always given as directed by the doctor. We saw one person was on morphine liquid for pain relief. This person had no medicines support plan or PRN plan in place to outline the circumstances in which this medicine should be given. The dose administered by staff differed from the dose prescribed by the hospital.

There were unopened items in a box of nail treatment for one person who used the service. When we checked the MAR chart there were no signatures on it to indicate that the medicines had been used for over a month. When we spoke with the person for whom the medicine was prescribed they told us the nail was very painful. We saw the nail in question was thick, yellow and looked untreated. There was no information in the person's care plan relating to the discontinuation of this medicine.

We found that stock quantities in the medicines trolley did not always match the signed for doses on the MAR charts for these medicines. The recording of stock levels on MARs not always complete or accurate. This meant that we could not identify if people had received their medicines as prescribed. It appeared in some cases that medicines had been signed for but not given. The MAR chart for one

Requires improvement

Is the service safe?

resident was duplicated and it was unclear if this medicine had been given twice or if the documentation had been duplicated as there was no record of stock obtained or carried forward on the MAR chart.

Stock control remained a concern throughout the visit and we checked stock disposal records. We saw that there was documentation to suggest that stock was being disposed of unnecessarily and not carried forward. We observed that on the MAR chart that where stock quantities were recorded and should have run out, administration was still being signed for. We spoke with the nurse on duty who told us she had borrowed stock from other residents. We spoke with the care manager who told us this should not be happening.

We noted the registered manager had introduced competence assessments to check that nursing staff were able to administer medicines safely. All except one member of nursing staff had received recent training in the safe administration of medicines.

The registered manager had undertaken regular medication audits. However, we found these had not been sufficiently robust to identify the shortfalls we noted during this inspection.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have appropriate arrangements in place for the safe handling of medicines.

The enforcement action we took:
We issued a warning notice