Sanctuary Care Limited

Yarnton Residential and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	
Is the service caring?	
Is the service responsive?	
Is the service well-led?	

Overall summary

We inspected Yarnton Residential and Nursing Home on 17 June 2015. Yarnton Residential and Nursing Home provides nursing care for people over the age of 65. Some people at the home were living with dementia. The home offers a service for up to 60 people. At the time of our visit 47 people were using the service. This was an unannounced inspection.

We carried out an unannounced comprehensive inspection of this service on 21 April 2015. One breach of the legal requirements was found. This breach was in relation to the management of people's medicines. After the comprehensive inspection, we issued a warning notice to provider requesting they take action to meet the fundamental standards by 31 May 2015.

Summary of findings

We undertook this focused inspection to check the service now met this legal requirement. 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 Yarnton Residential and Nursing Home on our website at www.cqc.org.uk

There wasn't a registered manager at the service. 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. A new manager had been employed by the provider and was starting the process to register with CQC.

The service had implemented a safe system for the management of medicines, which meant that people received their medicines as prescribed. There were clear systems of ordering and receiving medicines and administration was recorded clearly and accurately on medicine administration record (MAR) charts which were provided by the pharmacy.

There were no gaps in the administration records and where people had not received a medicine a code or reason had been recorded by staff. If there was a choice of how much medicine to give, the amount people received was clearly documented on their MAR charts. It was clearly marked on records when medicines were no longer required.

Medicines were stored safely and securely. All medicines were within their expiry and safe to use.

There was always a photograph of people for identification purposes available as part of their medicines records to ensure people received their medicines. People's allergies were always recorded. There were systems in place for people to self administer their own medicines, receive covert medicines, homely remedies and 'as required' medicines.

The home manager was doing spot checks and regularly reviewing people's medicine records to ensure that people received their medicines when they needed them. The home manager told us that staff had undergone additional training with regards to medicines administration since our last inspection.

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 safe. People received their medicines as prescribed.

Staff kept a clear record of when they had administered people's medicines. Staff had received additional training to ensure medicines were administered safely and accurately recorded.

There were effective and safe systems in place for people to receive 'as required' medicines.

We could not improve the rating for safe from April 2015 because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

Requires improvement 

Is the service effective?

Is the service caring?

Is the service responsive?

Is the service well-led?

Yarnton Residential and Nursing Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Yarnton Residential and Nursing Home on 17 June 2015. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our inspection in April 2015 had been made. The team inspected the service against one of the five questions we ask about services: is the service safe. This is because the service was not meeting this legal requirement at our inspection in April 2015.

The inspection team consisted of an inspector and an pharmacy inspector. We spoke with three of the 47 people who were living at the home. We also spoke with three care workers, the deputy manager, the manager and a regional manager.

We looked at the systems in place for managing medicines and 16 people's medicines administration records (MAR).

Requires improvement

Is the service safe?

Our findings

When we last inspected the service in April 2015 we found people were not always receiving their medicines as prescribed. Care and nursing staff did not always keep an accurate record of the medicines people received. This was breach of regulation 12(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice to the provider requesting they meet the regulations by 31 May 2015. At this inspection (June 2015) we found action had been taken to meet the fundamental standards.

There were clear systems of ordering and receiving medicines and administration was recorded clearly and accurately on medicine administration record (MAR) charts which were provided by the pharmacy. Staff told us that they had a good relationship with their supplying pharmacy and communication had greatly improved; they now met regularly on a monthly basis. The pharmacy had recently visited to audit the administration of people's medicines.

There were no gaps in the administration records and where people had not received a medicine a code or reason had been recorded by staff. However, sometimes the incorrect code had been used; the code for refusal was being used when patients were sleeping. If there was a choice of how much medicine to give, the amount people received was clearly documented on their MAR charts. It was clearly marked on records when medicines were no longer required.

People told us they were receiving their medicines as prescribed. All medicines were in stock and there was a clear system in place to document the amount of medicines kept within the home. Medicines were available when people needed them. Any handwritten changes to the MAR charts had been checked by another member of staff.

Medicines were stored safely and securely, in locked medicine trolleys which were secured to walls, and in locked cupboards within a secure treatment room. Medicines requiring cold storage were kept within a monitored refrigerator in the treatment room. Some liquid medicines had dates of opening on them but all eye drops and topical medicines were clearly marked with their expiry. All medicines were within their expiry and safe to use.

There was always a photograph of people for identification purposes available as part of their medicines records. People's allergies were always recorded. There were clear processes in place for people requiring monitoring of their medicine's dosage by means of a blood test. No one was self-administering their own medicines but there was provision within the home should people express a wish to do so.

Protocols for the administration of 'as required' medicines were available. These protocols provided guidance as to when it was appropriate to administer an 'as required' medicine and ensured people received their medicines in a consistent manner. We were assured that all people within the home were having their 'as required' medicines offered to them when they needed them.

There was a clear procedure for giving medicines to people when they left the home for day trips or social leave; we saw that in one case this had not been followed accurately but the action of the staff was appropriate and made sure that the person did not miss any doses of the medicine that had been left behind.

Three people were receiving their medicines covertly which means they were hidden in food or drink. There was a record of the decision making process and who was involved, including the GP, family member or advocate and the pharmacist. For two people where medicines were being administered covertly the records indicated that the people were still refusing their medicines. It was unclear from the documentation to what extent staff had tried to ensure that these people received their medicines. We spoke with staff who informed us people received their medicines and were reporting concerns to the manager and people's GPs.

Topical medicines such as creams and ointments for preservation of skin integrity were being applied by care staff and documentation was stored in people's records in their rooms. There were clear records for the site of application of medicines administered as patches. A current British National Formulary (BNF) was available for

Requires improvement

Is the service safe?

reference for nursing staff should they require it. BNFs provide the most up to date reference source for information for all health care professionals regarding medicines.

The home manager was carrying out spot checks and regularly reviewing people's medicine records to ensure people received their medicines when they needed them.

The home manager told us staff had undergone additional training with regards to medicines administration since our last inspection. We saw that all our previous concerns had been addressed and that the actions that had been put into place ensured people received their medicines safely and appropriately.

Is the service effective?

Our findings

Is the service caring?

Our findings

Is the service responsive?

Our findings

Is the service well-led?

Our findings