T. L. C. Homes Limited

Park House Nursing Home

Inspection report

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Ratings

Is the service safe?	Good

Overall summary

We carried out an unannounced comprehensive inspection of this service on 9 December 2014. A breach of two legal requirements was found. This was because people were not protected against identifiable risks of acquiring an infection and people had not always received their medicines as required.

After the comprehensive inspection the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this unannounced focused inspection on 26 August 2015 to check that the provider had followed their plan and to confirm that they now met legal requirements.

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 Park House Nursing Home on our website at www.cqc.org.uk.

Park House Nursing Home is registered to provide accommodation, nursing care and personal care for up to 52 older people and people living with dementia. At the time of our inspection there were 48 people living in the home.

Accommodation is provided on two floors. People have single bedrooms with en suite facilities of a toilet and sink. There are communal baths and showers. There are gardens and internal communal areas, including dining rooms and lounges, for people and their visitors. The home is located in a residential area on the outskirts of Peterborough.

The home had a registered manager in post at the time of the inspection. 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.

Summary of findings

At our focussed inspection on 26 August 2015 we found that the provider had followed their plan which they told us would be completed by 31 May 2015 and legal requirements had been met.

Action had been taken and all communal toilets and bathrooms now had paper towels available for people, their relatives and staff. Sluice rooms now had locks, sinks and paper towels for staff to use.

People were supported to take their prescribed medicines. Staff understood their responsibilities in the management and recording of medicines. Medication audits had taken place each month and actions had been taken as a result of any issues identified.

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?

Good

We found that action had been taken to improve the safety of the service.

Action had been taken to ensure that the risk to people of cross contamination had been minimised. The provider had ensured paper towels were available in all communal toilets and bathrooms. Action had been taken to keep people safe from entering the sluice rooms.

This meant that the provider was now meeting the legal requirement.

Action had been taken to improve the management of people's medicines through the review of the medication policies and procedure and medication audits. Staff had received further training. People had all their prescribed medicines administered as prescribed.

This meant that the provider was now meeting the legal requirement.

Park House Nursing Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Park House Nursing Home on 26 August 2015. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection of 9 December 2014 had been made. We 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 legal requirements in relation to that question.

The inspection was undertaken by one inspector.

Before our inspection we looked at all of the information that we held about the home. This included the provider's action plan, which we received on 14 July 2015.

During our inspection we spoke with two people who lived in the home. We also spoke with two nurses, the registered manager and the clinical lead. We looked at four people's medication administration records. We looked at policies and procedures.

Good

Is the service safe?

Our findings

At our comprehensive inspection of Park House Nursing Home on 9 December 2014 we found that the provider was not able to demonstrate that people were protected against the risk of infection because there were only fabric towels available in the communal baths and toilets. There were no risk assessments in place in relation to potential cross contamination and the use of fabric towels.

There were no locks on the sluices, which meant people could enter and touch items that could be contaminated.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our focussed inspection on 26 August 2015 we found that the provider had followed the action plans they had written to meet shortfalls in relation to the requirements of the Regulation described above.

We saw that the provider had removed fabric towels from the communal bathrooms and toilets. Paper towels had been provided in all sluices, communal toilets and bathrooms and in some the addition of air hand dryers. There were risk assessments in place regarding the potential cross contamination when fabric towels were used in people's en suite facilities. We saw that there had been locks added to keep people safe from entering the sluice rooms.

There was weekly steam cleaning of all appropriate surfaces and floors in the home to prevent infection or cross contamination.

At our comprehensive inspection of Park House Nursing Home on 9 December 2014 we found that staff had signed the medication administration record (MAR) before the person had taken them. We found that information on the MAR was recorded 'as directed', but staff were not aware of the specific directions and whether the particular medicine should have been given before, with or after meals.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our focussed inspection on 26 August 2015 we found that the provider had followed the action plan that they had written to meet shortfalls in relation to the requirements of the Regulations 13 described above.

People told us that they were satisfied with how they were supported to take their medicines. One person said, "I have paracetamol and I know when I should take them, and I do get them when I need them." Another person said, "I take paracetamol for the pain. Staff [nurses] ask me if I want it and if I'm in pain I say yes. The nurses are perfectly clear and I ask questions [about any medication] if I need to."

Nurses told us they had received further training in administration and management of medicines. They were able to tell us about specific medicines and how they should be administered (before, with or after meals). One nurse said, "If I'm not sure I go to the BNF [British National Formulary a medical book that explains about each medicine and its side effects] to ensure it is being given appropriately." Nurses told us when they recorded the administration of medication on the MAR's, which was always after medication had been taken. We observed that this was the case.

We saw that monthly audits had been completed to check a number of subjects such as the numbers of tablets in the home were correct. These audits also checked to make sure there were no packets of medication with 'as prescribed' in the home and MAR charts had been completed accurately. Overall, the audits had found few medicines that could not be reconciled. If there were discrepancies the manager and clinical lead said that actions were taken and there was evidence that these had been completed.

The registered manager told us they had discussed the issues regarding medication with nurses who administered them. Nurses confirmed to us that they had acknowledged the issues which had been identified as requiring improvement. We were shown meeting minutes that showed there had been further discussions about medication administration and recording in the regular nurses meetings and nurses agreed this had been done. This meant that the risk of people being supported safely with their medicines was increased.

The providers medication policies and procedures had been reviewed and updated in April 2015 and discussed in nurses meetings held in the home. This showed that nurses were aware of the requirements to administer medicines safely.