Care Worldwide (Nottingham) Limited

Beechdale Manor Care Home

Inspection report

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Ratings

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

Summary of findings

Overall summary

This unannounced focused inspection took place on 3 November 2016. Beechdale Manor Care Home provides accommodation and nursing care for up to 65 older people, some of whom are living with dementia, over three floors. On the day of our inspection there were 46 people living at the service.

We carried out an unannounced comprehensive inspection of this service on 16 and 17 August 2016. Breaches of legal requirements were found. We issued warning notices in relation to two of these breaches.

We undertook this focused inspection to confirm that the provider had met the requirements of one of these warning notices. This report only covers our findings in relation to those requirements. We will be following up the other warning notice at a later date once the date of required compliance has passed. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Beechdale Manor Care Home on our website at www.cqc.org.uk.

The service did not have a registered manager in post as they had stopped working as the manager in May 2016. An interim manager was in place at the time of our inspection. A new manager had been recruited and was due to commence working at the service shortly after our visit. 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 our last inspection on 16 and 17 August 2016, we asked the provider to take action to ensure that people were provided with safe care and treatment through the proper and safe management of medicines.

During this inspection, we found that action had been taken to improve the storage and administration of medicines, however further improvements were required to ensure people were given their medicines as prescribed and medicines were managed safely.

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

Inadequate

People were at risk of not receiving the medicines they had been prescribed and in some cases they had not done so.

People might not always have medicines they need because records did not show when they could be administered safely.

Improvements had been made to the storage of medicines so these were at their most effective.

We could not improve the rating for safe from inadequate because to do so requires consistent good practice over time. We will check this during or next planned comprehensive inspection.

Beechdale Manor Care Home

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.

The inspection took place on 3 November 2016 and was unannounced. The inspection was carried out to check that improvements had been made to meet legal requirements following our comprehensive inspection on 16 and 17 August 2016. We inspected the service against one of the five questions we ask about services: Is the service safe? This is because Beechdale Manor Care Home was not meeting some legal requirements and we had taken enforcement action which required the service to improve.

The inspection was undertaken by a CQC pharmacy specialist. During the inspection we spoke with the clinical lead, a regional support manager and peripatetic manager. We looked at the medicines administration records of 16 people who lived at the service as well as the storage of medicines. We observed staff administering medicines.

Inadequate

Is the service safe?

Our findings

At our last inspection on 16 and 17 August 2016, we asked the provider to take action to ensure that people were provided with safe care and treatment through the proper and safe management of medicines. This was because safe procedures for the administration and management of medicines were not followed. During this inspection, we found that although there had been some significant improvements there were continued concerns that people's medicines were not always given as prescribed.

During our last inspection there were a large number of gaps in the medicines administration records (MAR) indicating either staff had not administered people's medicines on occasions or they had not signed for the administration. During this inspection, we found a number of gaps in people's MAR charts.

Medicines were available to give to people. Records documented the date and actual amount received from the pharmacy; however we could not always be assured that people were given their medicines as prescribed. We found gaps in six people's MAR chart. This is when there is no staff signature to record the administration of a medicine or a reason documented to explain why the medicine had not been given. We identified that one person had not been given their medicine for two evenings and another person had not been given three medicines for one evening. We established that the people concerned had not been given their medicines because their medicines were still in the medicine trolley. We also found that there was no record documented to explain why they had not been given. This meant that medicines were not being effectively managed to ensure people received them as prescribed.

The management team told us that regular checks after each medicine round had been undertaken by staff; however the clinical lead said that, "This may have dropped off over the last two weeks." Staff had not identified people were not given their tablets as prescribed by checking the MARs had been completed correctly, therefore no action had been taken to rectify this and give people the medicines they required. During the inspection the management team identified that the gaps in the MAR chart were due to one member of staff. We were told that further checks and supervision would be undertaken to ensure this staff member was administering medicines correctly.

We found that when people were prescribed by their doctor a variable dose of a medicine such as 'give one or two tablets' the actual amount was not always recorded on the MAR chart. It was therefore not possible to determine if the person had been given the maximum prescribed dose or if a second dose could be given safely if needed. This is particularly important for pain relief medicines. This meant that medicines were not always effectively managed to ensure people received them safely.

This was an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A review of medicine management processes at the service was undertaken by Nottingham City Care Commissioning Group (CCG) medicine management team. We were shown a copy of the report dated 24 October 2016 which had found there had been improvements in how medicines were managed within the

service and they were awarded a score of 91%. However the report noted that some areas although 'much improved' still required further work. It was these same areas where we also found issues of concern. The management team told us that a 'lot of hard work' had been undertaken in improving medicine management and they were disappointed that similar concerns were identified.

People's medicines were labelled individually and kept secured in locked medicine trolleys. The keys for medicine storage were held by the nurse or the senior care worker. We observed that medicines were stored neatly which made it easy to locate people's medicines. We observed medicines being administered by staff safely.

Medicines were stored within the recommended temperature ranges for safe medicine storage. Daily temperature records were available which recorded the temperatures for the medicine refrigerator as well as the medicine room, which was air conditioned.

When people were prescribed a cream or ointment to be applied on different parts of the body there were body map diagrams to highlight to staff where to apply the preparation. Records of application were available which demonstrated that staff were applying creams or ointments as prescribed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People could not be assured that medicines were given as prescribed and managed safely.