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Asquith Hall EMI Nursing Home

Inspection report

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Date of inspection visit: 18 May 2015
Date of publication: 14/07/2015

Ratings

Is the service safe?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 15 July 2014 . A breach of legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the management of medicines.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk

Asquith Hall provides nursing and personal care for up to 53 people with dementia and mental health needs. The service is divided into two units on separate floors. The manager told us there were 52 people using the service on the day of our inspection.

There was 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.

Although we observed some good practice in the management of medicines, we found there were occasions when people had not been protected against the risks associated with medicines. This included gaps in recording, medicines running out of stock and a lack of guidance for staff in how to administer 'when required' medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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 consistently safe. Although we saw some good practice in the handling of medicines, we found action had not been taken to ensure that people always received their medicines as prescribed.

This meant people were at risk of harm as their medicines were not consistently handled safely.

Requires improvement 

Asquith Hall EMI Nursing Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Asquith Hall EMI Nursing Home on 18 May 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our inspection on 15 July 2014 had been made.

The inspection was undertaken by a lead inspector and a pharmacist inspector.

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 legal requirements in relation to medicines.

During our inspection we spoke with the clinical services manager, the deputy manager and two nurses. We looked at the medicines and medicine records for 23 people who used the service.

Requires improvement

Is the service safe?

Our findings

At our two previous inspections in January and July 2014 we found people were not protected against the risks associated with the unsafe handling of medicines.

During this inspection we looked at records about medicines and medicines for 23 people. We saw there was some good practice around medicines handling however we still found concerns about medicines safety for 22 people. This meant that overall people were still at risk because medicines were not being handled safely.

Medicines were stored safely in dedicated medication rooms which only staff authorised to administer medicines could access by the use of a specially programmed swipe card. However, we found that creams were not stored securely in people's bedrooms and there were no risk assessments to show it was safe to do so. A nurse told us that one person must not have their creams stored in their bedroom because they were at risk of ingesting the cream. However, we found that their creams were kept in their bedroom. This meant that they were at significant risk of harm. After our inspection the manager told us the creams had been removed from the bedroom and were stored in the treatment room.

During our inspection we saw there were arrangements to obtain medicines for people at the start of each monthly cycle. However, we found that eight out of the 23 people whose records we looked at had missed doses of their medicines because they were "out of stock". People were out of stock of their medicines for between two days and two weeks. We saw that it was recorded that one person had been very upset and agitated because they had missed doses of their medicines .If people miss doses of their medicines their health is at risk of harm.

We saw that medicines were not always administered safely. On the day of our visit we found there were just over 2 hours between the end of the morning medicines round and the start of the lunch time round. The actual time of administration of medicines such as Paracetamol (which must have a minimum of four hours between doses) was not recorded. It was possible that people could be given their doses of pain relief unsafely because nurses did not record the time of administration.

We saw people missed doses of their medicines because they were asleep. We saw that one person had missed their night time doses of a medication for epilepsy for three weeks before any changes were made to the time they were given their 'bedtime' dose of medicines.

We saw when people had the dose of their medicines changed they were not always given the new doses properly. On the day of our visit we saw that one person missed two of their morning doses of medication to control their symptoms of Parkinson's. If people are not given their medicines when they need them and as prescribed their health may be at risk of harm.

At this inspection we looked to see if there was clear guidance (protocols) for staff to follow to enable them to give people their medicines which were prescribed 'when required' or as a variable dose, safely and consistently. We found that there was some guidance in place for medicines to be taken 'when required' but the information was not tailored to each person's individual needs and it was not possible to know how to administer their medicines safely . When new 'when required' medicines had been prescribed we found there was no guidance available for staff to follow. We also found there was no information to guide staff about which dose of medication to administer when a variable dose was prescribed. People's health is at risk of harm if this guidance is not available.

We saw that some people needed to be given their medicines covertly. This is usually done by hiding medicines in food or drink and a plan of how to do this safely must be prepared in conjunction with the pharmacist and other professionals. However, there was no such plan in place for one person whose records we looked at.

We saw that records about medicines administration failed to show people were given their medicines properly. We found there were gaps on the records where it was not possible to tell if people had been given medicines. We saw the records about the application of creams were not well completed and failed to show that creams had been applied properly. We were told that five people were prescribed a thickening agent. Thickeners are prescribed to help people with swallowing difficulties drink fluids without choking or aspirating. However, we found there were no records that thickener had been used. We also found when people's needs changed, the information recorded for staff

Requires improvement

Is the service safe?

to use when administering medicines was not updated. Records about the administration of medicines must be accurate and up to date to ensure that people are given their medicines safely at all times.

This was a breach of Regulation 12 Heath and Social Care Act (Regulated Activities) Regulations 2014.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered provider had not ensured the proper and safe management of medicines or that there were sufficient quantities of medicines to ensure the safety of service users and to meet their needs.

The enforcement action we took: