Great Marsden Residential Limited

Nelson Manor Care Home

Inspection report

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09 March 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

This focussed inspection was carried out on the 9th March 2016. This was an unannounced inspection which meant the staff and provider did not know we would be visiting.

Nelson Manor is a purpose built care home registered to provide personal and nursing care for up to 70 people. There were 47 people accommodated on the day of the focussed inspection. The home is located approximately one mile from Nelson town centre in a residential area. Accommodation is provided on three floors and each floor has a unit manager. The ground floor provides personal care for older people, the middle floor known as the Jubilee unit provides personal and nursing care for people living with a dementia and the third floor provides nursing care.

There was no registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law. 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.

We previously visited this home for an unannounced comprehensive inspection on 3, 4 and 5 November and 9 and 10 December 2015. During that visit, we found people were not protected against the risk associated with the unsafe management of medicines and issued the provider with a warning notice.

As part of this focussed inspection, we checked to see that improvements had been implemented by the service in order to meet the requirements of the warning notice. This report only covers our findings in relation to those requirements. Reports from our last comprehensive inspections are available on our website by selecting the "all reports" link for Nelson Manor at www.cqc.org.uk.

At this inspection on 9 March 2016 we looked at arrangements for the management of medicines and found that improvements had been made. We reviewed the providers action plan and saw evidence of the actions they had taken on our visit.

A pharmacist specialist carried out the inspection and we looked at the management of medicines. There had been concerns on a previous inspection that there were delays in obtaining medicines. This meant people using the service sometimes went without prescribed medicines because they were not available in the home. We saw improvements had been made to the ordering process for repeat medicines to ensure people got their medicines on time and that regular stock checks were being carried out. We found no incidences on this inspection where people had not received their medicines as prescribed because they were not available. This was an improvement in comparison with our previous visit.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was safe but some improvements were required.

Systems were in place to ensure people received their medicines safely. Records of the application of creams were incomplete and care plans to outline how people preferred to take their medicines were not always available.

We could not improve the rating for "safe" from 'requires improvement' at this time because to do so required evidence of consistent good practice over time. We also only looked at the safe management of medicines on this focussed inspection rather than all aspects of the question "Is the service safe?" This will be reviewed during our next comprehensive inspection.

Nelson 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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focussed inspection at Nelson Manor on 9th March 2016. The inspection was completed to check whether the provider had met the requirements of the warning notice which was issued following the focused inspection in November and December 2015. The warning notice was issued as people were not protected against the risks associated with the unsafe management of medicines.

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.

This inspection was undertaken by a Pharmacist Specialist. Before the inspection we reviewed the information the provider had sent to us about the actions they had taken following our previous inspection. During this inspection we spoke with the manager of the home, one nurse, two unit managers and two senior carers with responsibility for medicines.

Requires Improvement

Is the service safe?

Our findings

We previously visited this home On 3, 4 and 5 November and 9 and 10 December 2015 and found them to be in breach of Regulation 12(2) (g) the proper and safe management of medicines; of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As part of this focussed inspection we checked to see that improvements had been implemented by the service to meet legal requirements. At this inspection we found that improvements had been made. We reviewed the providers action plan and saw evidence of the actions they had taken on our visit.

At this inspection we checked the medicines records for 15 people. We found no incidences on this inspection where people had not received their medicines as prescribed due to them not being available in the home. Staff could tell us about the new ordering process and we saw evidence of the checks they carry out to ensure all medicines were received on time. We saw medicines being booked in to one unit for the start of the next month and this supported what staff had told us.

We saw evidence of regular stock checks, balance checks and audits to reduce the risk of someone running out of medicine. We saw incident forms had been completed where a problem had been identified, and the actions taken as a result of the incident.

Appropriate quantities of medicines were kept safely and stored securely. We checked the medicines disposal records and found these clearly detailed medicines that were returned or destroyed and the reasons for this. We found that controlled drugs (CDs - medicines which are more liable to misuse and therefore need close monitoring) were stored securely. Registers were in place to record the handling of CDs and we saw evidence of regular balance checks. Fridge temperatures were recorded daily and within the recommended range. The provider had identified a problem with recording maximum and minimum fridge temperatures on some units and we saw documentation that this was being addressed.

We observed a "ten at ten" meeting and saw that staff had a good knowledge of residents and used this forum to discuss any medicines issues. This included discussion about anyone who was on anti-biotics, catheters, people who were PEG fed (Percutaneous Endoscopic Gastrostomy, a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach) and people who may have problems with nutrition and hydration.

Staff could tell us how people liked to take their medicines and we saw clear, thorough documentation was available to support staff to give people their medicines according to their preferences. In five of the 15 records we looked at this information was missing. This meant that in these cases there was a risk that new or inexperienced staff may not have had enough information about how a person liked to take their medicines where the resident was unable to communicate verbally. The provider told us they were addressing this. It was identified on their action plan to ensure everyone had a "medication profile" in place and we saw steps had been made towards this being completed.

Appropriate arrangements were in place for recording medicines. There was a process in place for

monitoring these records regularly to check they were completed correctly. We saw action had been taken to follow up any problems that had been identified during these checks.

We saw the use of patch charts for a person using the service who needed a pain relief patch. This meant it was clear to staff where and when patches had been applied, and reduced the risk of harm from duplicate application. Body maps and topical Medicines Administration Records (MARs) were also in use in the service and these detailed where creams should to be applied. In four of the eight records we looked at, the topical MARs for cream application were not complete so it was not always possible to confirm they had been applied to people as prescribed.

We looked at the information available to staff for medicines to be administered "when required." Some people did not have "when required" plans in place for all their medicines. We found that there was additional documentation in place for ten of the 15 medicines we looked at and these were reviewed where appropriate. However, we found some incidences where guidance was not available for staff if there was a variable dose. For example, details of the situations where someone might need to take one tablet or situations where someone might need to take two tablets. This meant that in these cases there was a risk that new or inexperienced staff may not have had enough information about how a person liked to take their medicines where a resident is unable to communicate verbally. We recommended the provider reviews the "when required" plans they have in place to ensure information is available for all people using the service.

We saw evidence that medication reviews had been carried out for a person where medicines were given covertly (given in food or drink without their knowledge) and saw that there was appropriate documentation in place. This included evidence of a Multi-Disciplinary Team (MDT) best interests meeting and clear instructions on how the medicine should be given.

We looked at how medicines were monitored and checked by management to make sure they were safe and handled appropriately. We found that the provider was completing regular medicines audits and where issues had been identified these were being actioned.

We saw that all staff who were responsible for administering medicines in the service had completed recent training in the safe administration of medicines.