Nethercrest Care Centre (Dudley) Limited

Nethercrest Residential Home

Inspection report

Brewster Street
Netherton
Dudley
West Midlands
DY2 0PH
Tel: 00 000 000
Website: www.example.com

Date of inspection visit: 1 February 2016
Date of publication: 26/05/2016

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 28 October 2015 at which a breach of a legal requirement was found. We asked the provider to take action to make improvements to how they managed people's medicines. This was to make sure people's medicines were managed safely.

After our comprehensive inspection on 28 October 2015 the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. They sent us an action plan setting out what they would do to make the improvements and meet the legal requirements and when their actions would be completed by.

We undertook this focused inspection on 1 February 2016 to check the provider had followed their plan and to confirm they now met the 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 Nethercrest Residential Home on our website at www.cqc.org.uk.

The provider for Nethercrest Residential Home is registered to provide care and accommodation for up 43 people who may have dementia. On the day of our inspection there were 33 people living at the home.

The registered manager was present during our 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 focused inspection on the 1 February 2016, we found that the provider had taken action and legal requirements had been met. This is because our Pharmacist Specialist found that sufficient improvements had been made to ensure people's medicines were managed safely.

This report only covers our findings in relation to our following up of the previous breach. You can read the report from our last comprehensive inspection by selecting the all reports link on our website at www.cqc.org.uk.

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?

We always ask the following five questions of services.

Is the service safe?

We found that action had been taken to improve the safety of people's medicines.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for safe at the next comprehensive inspection.

Requires improvement

Nethercrest Residential 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.

This was an unannounced focused inspection which was undertaken on 1 February 2016 by a CQC Specialist Pharmacist inspector. The purpose of our inspection was to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 28 October 2015 had been made. We inspected against one of the five questions we ask about services; 'Is the service safe?' This is because the provider was previously not meeting some legal requirements in relation to this question.

We checked the information we held about the service and the provider. This included the provider's action plan, which set out the action they would take to meet legal requirements. We requested information about the service from the pharmacist from the local Clinical Commissioning Group. They have responsibility for monitoring the service quality.

On the day of our inspection we spoke with the registered manager. We looked at nine people's medicine records and the overall management of people's medicines.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection on 28 October 2015, we found people did not have their medicines as they were prescribed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this focused inspection the provider had made the required improvements to ensure they were meeting the law around Regulation 12.

At the previous inspection on 28 October 2015 we identified concerns with how medicines were managed. Since then a pharmacist from the local Clinical Commissioning Group (CCG) had provided on-going support to the service to improve the handling of medicines. At this inspection we looked at how medicines were handled which included looking at nine people's Medicine Administration Record (MAR) charts. We found that the arrangements for medicine management had significantly improved which were person centred at all stages.

Daily medicine checks were undertaken which ensured consistent standards were maintained. The manager told us about a medicine error that had been identified during one of the routine checks. We found that the medicine error was dealt with immediately with action taken to prevent it happening again. There was an open culture of reporting medicine problems with lessons learnt.

People's medicines were available to give to treat their diagnosed health conditions. Medication Administration records [MAR] charts were completed to document that people had been given their prescribed medicines or a reason was documented to explain why a medicine had not been given. We also found that arrangements were in place for accurate medicine stock checks. This meant it was possible to check the balance of all medicines to ensure they had been given as prescribed. We found that all the balances we checked were accurate. The registered manager told us they had, "Worked together to make medicines safe with the CCG pharmacist". The CCG pharmacist told us, "They have worked well to improved medicine management".

Supporting information for staff to safely administer medicines was available and easily accessible. We saw detailed information on how people preferred to be given their medicines. This was helpful for staff who may not be familiar with a person's specific needs. There was clear documentation for the site of medicine patch applications on a person's body. This is particularly important for pain relief medicines. Arrangements were in place to ensure that medicines which needed to be given at specific times were clearly highlighted on the MAR charts with reminders also displayed.

When people were prescribed a medicine to be given 'when required' we found that person centred supporting information was available to enable staff to make a decision as to when to give the medicine. When people were given a medicine prescribed 'when required' a record was made to explain why the medicine had been given.

People's medicines were labelled individually and kept secured in locked medicine trolleys. Controlled drugs which require separate secure storage arrangements were stored securely in dedicated controlled drug cupboards. 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 and the medicine room temperature.