Cambridge Nursing Home Ltd

Cambridge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good

Summary of findings

Overall summary

This inspection took place on 24 August 2016 and was unannounced. At the last inspection on 14 April 2015, we found people who used the service were not protected against the risks associated with unsafe management or administration of medicines. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the comprehensive inspection, the provider wrote to us in July 2015 to say what they would do to meet legal requirements in relation to the breach.

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 Cambridge Nursing Home on our website at www.cqc.org.uk.

Cambridge Nursing Home is a care home with nursing provided on three floors. The service is registered to accommodate a maximum of 49 people. At the time of the inspection, there were 49 people using the service.

There was a registered manager in place. 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.

At this inspection we found the registered provider had taken sufficient action to ensure people received their medicines as prescribed and medicines were managed safely.

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

The service was safe. It had suitable arrangements to protect people against the risks associated with the unsafe management of medicines, which included the obtaining, recording, administering, safe keeping and disposal of medicines.

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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 inspection was undertaken to check that the provider had made improvements to meet legal requirements after our 14 April 2015 inspection. We inspected the service against one of the five questions we ask about services: Is the service safe? This is because medicines were not always safely managed. This inspection took place on 24 August 2016 and was unannounced.

Before our inspection we reviewed information we held about the service and the provider, such as the action plan the provider submitted setting out how they would become compliant with the breach identified at the previous inspection.

During the inspection we spoke with a senior nurse, two nurses and four people who use the service. We looked at 14 people's medicine administration records, training records on medicines management and a report of the last visit from the pharmacist who supplied medicines to the service.

Good

Is the service safe?

Our findings

At the last inspection in April 2015, we found a breach of the regulation 12 in relation to the safe administration of medicines. We checked the balances of medicine in stock against the medicine administration record sheets (MARS) for 10 people and found five of these records were not accurate. We found medicines in stock for these five people did not match with the medicines in stock on their MARS. Staff told us they did not use a medicines' reconciliation sheet to check stock balances. This meant there was not always a suitable system in place to account for medicine and to check to ensure people had the right quantity of medicines required.

We also noted some people were prescribed medicines to be given only when needed, such as pain relieving medicines. We saw that although there was a policy in place to provide staff with some instructions on how to administer these medicines, the policy was not always followed. There was also no protocol in place for each person who required medicine, when needed. This indicated that staff did not have the necessary information for when to administer 'as required' medicines.

During this visit we saw people were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines. People were happy with the way the service managed their medicines.

We looked at the medicines administration records and saw that they were all up to date and had been signed for, when medicines had been administered or refused. People had received the correct amount of medicine at the right times. This meant people were taking their medicines as prescribed by their GPs.

Each person that required medicines had an individual medicine administration record chart which clearly stated the person's name, date of birth and allergy status. The service used a recognised monitored dosage system with clear instructions to administer medicines. The staff monitored people's medicines regularly for evidence of any potential side effects or adverse reactions. We noted the GP visited the service every Tuesday and if needed, they reviewed people's medicines during these visits.

Where people were prescribed medicines to be given only when needed, staff had contacted the GP for guidance as to when these should be administered. For example, we saw the GP had stopped all the 'as required' medicines for one person, as they did not need them anymore.

Staff had completed medicine administration training in October 2015. These arrangements helped protect people from the risks associated with medicines mismanagement because the staff had been assessed as competent to administer medicines safely.

The pharmacist supplying medicines to the service visited regularly and was available for advice at any time. We saw they visited in July 2015 and they were going to visit again in September 2016.

There were systems in place to ensure people did not run out of their medicines. Staff monitored the stock

level of medicines for each person and requested them from the GP's surgeries accordingly.