Lifestyle Care Management Ltd

Coniston Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 10, 11 and 12 January 2017. Following this inspection, concerns were raised with us about the way the service ordered and looked after people's medicines and the use of thickening agents used in people's drinks. We undertook a focused inspection on the 8 and 9 May 2017 to check how medicines were looked after. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Coniston Lodge Nursing Home' on our website at www.cqc.org.uk

Coniston Lodge Nursing Home is a nursing home and is part of Lifestyle Care Management Ltd. It provides accommodation for up to 92 older people in single rooms. The service has four units but at the time of our inspection only three were in use. The home is situated within a residential area of the London Borough of Hounslow. At the time of our visit there were 42 people using the service.

At the time of the inspection there was no registered manager in post. An interim manager had been in post for two weeks before the 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.

The provider had appropriate processes in place for the ordering of medicines.

Systems were in place for the safe administration of medicines.

Medicines were stored safely and securely.

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

We found that medicines were looked after safely.

The provider had appropriate processes in place for the ordering of medicines.

Systems were in place for the safe administration of medicines.

Medicines were stored safely and securely.

We could not improve the rating of this domain because this rating related to breaches of regulations identified at the previous inspection which have not been reviewed.

Coniston Lodge Nursing 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 was 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 a focussed inspection and took place on 8 and 9 May 2017. It was unannounced. This inspection was completed to check that safe systems were in place for the management of people's medicines. We inspected the service against one of the five questions we ask about services: is the service safe. This is because, since our last inspection in January 2017, concerns had been raised with us about the way the service ordered and looked after people's medicines and the use of thickening agents used in people's drinks.

The inspection was undertaken by one medicines inspector.

Before our inspection we reviewed all the information about concerns relating to medicines that had been received by the Care Quality Commission since the last inspection.

During this inspection we spoke to the interim manager, deputy manager, three nurses, and three care staff. We looked at the arrangements for ordering, storing, and administering medicines. We looked at 29 people's medicines administration records, and two people's care records in relation to their medicines. We also looked at three recent medicines audits carried out by staff.

Requires Improvement

Is the service safe?

Our findings

Suitable arrangements were in place for ordering people's medicines. Staff told us they checked the medicines received with the medicines administration records (MARs) and a copy of their order, to make sure the correct medicine were supplied. We saw copies of the medicines requests for the previous month and confirmation the GP had prescribed these medicines. Records showed that people's medicines were available for them.

Staff told us that no one currently living in the service looked after their own medicines. Medicines were given by qualified nurses, who were trained to do this. The pharmacy provided printed MARs for staff to complete when people had taken their medicines. Staff had completed records clearly, which helped to assure us that people had received their medicines as prescribed for them.

The pharmacy supplied most medicines using a monthly blister pack system. For medicines supplied in standard packs staff checked the stock balance and kept a running total. This helped staff assure themselves that people had received their medicines as recorded. We saw a mistake in the running total for two medicines for one person and staff had not recorded the reason for this. This meant staff could not be sure that the person had their medicine correctly on these two occasions. This was pointed out to staff at the time of the inspection. The interim manager had introduced a daily checking system where the nurses checked the MARs from a different unit to make sure they had been completed properly. However this was not currently recorded. We saw a form that was to be introduced for staff to record the outcome of these checks and any action taken. This system should help staff identify any mistakes very quickly and assure themselves that people had received their medicines safely as prescribed.

Some people were prescribed a medicine for a particular medical condition and this had a variable dose depending on the results of blood tests. We saw the results of the most recent blood test and current dose with people's MARs. Additional records were kept of the administration of these tablets and the running stock balance. This meant staff could check this medicine had been given safely and correctly.

Some people needed a thickening agent to be added to their drinks to help their swallowing and reduce the risk of choking. We saw that people had their own labelled supply of this product. Information about how much to use and the consistency needed for each person was available in people's rooms, in the satellite kitchens where staff prepared people's drinks and with people's MARs. This helped to ensure that staff giving people drinks had the information to make these to the safe consistency.

Medicines were stored securely in locked medicines cupboards within a locked clinic room. Each floor had a medicines refrigerator. Staff checked the temperature of the refrigerators twice daily. Records showed that these were in the safe range for storing medicines. Suitable arrangements were in place for storing and recording medicines that needed additional security. This helped to ensure that people's medicines were looked after safely and were available for them.