Springdene Nursing And Care Homes Limited

Springview

Inspection report

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Ratings

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

Overall summary

At our last inspection of this service on 13 August 2014 the provider was in breach of the regulation relating to medicines management, Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). The provider sent us an action plan after the inspection detailing how they would meet this standard. At this inspection we found although progress had been made, the provider continued to be in breach of this standard.

This inspection took place on 8 February 2016 and was unannounced. This inspection was carried out by a single pharmacist inspector. This report only covers our findings in relation to the safe management of medicines within the safe section. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Springview on our website at www.cqc.org.uk

Springview provides accommodation for 58 older people some of whom have dementia.

The manager of the home has applied to be registered with the Care Quality Commission (CQC). 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 and associated Regulations about how the service is run.

Some of the issues we found with medicines at the last inspection had been addressed. However the revised medicines policy had not been fully implemented in 2015 as the provider told us it would be.

We found that the process for covert administration was still unsafe, and one person had continued to be placed at risk of unsafe medicines administration since our last inspection.

Information on as required medicines (PRN) and risk-assessments for people self-administering medicines were not yet in place, as required by current national medicines guidance.

Summary of findings

The provider was still in breach of the medicines regulation, Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

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 always safe. Although the provider had made a number of improvements to the management of medicines, people were still being placed at unnecessary risk because staff were not following the service's own medicine policies and procedures.

Requires improvement

Springview

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 checked 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 focused inspection of Springview on 8 February 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our last inspection on 13 August 2014 had been made. We 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 some legal requirements.

The inspection was carried out by a single pharmacist inspector.

Prior to the inspection we checked the action plan that the provider sent us following the inspection in August 2014. We also looked at notifications the provider had sent us that are required by law under the Health and Social Care Act 2008. During the inspection we looked in detail at records relating to the safe management of medicines at the home.

Requires improvement

Is the service safe?

Our findings

At our last inspection of the service on 13 August 2014, although the service was managing some aspects of medicines safely, we found that the provider was in breach of the regulation relating to medicines management.

Medicines requiring refrigeration were not always stored and used safely. The medicines error reporting procedure was not always followed when there were issues with people's medicines.

For medicines prescribed as a variable dosage, staff did not record the actual dose given. There were insufficient instructions for care workers on how often and where to apply prescribed creams.

There were no formal documented assessments of the competency of staff to administer medicines. Some people were prescribed medicines to be given only when needed, for example pain relieving medicines for people who were not able to communicate verbally when they were in pain. We saw that there were insufficient instructions for staff to enable them to administer these medicines correctly and there were no formal pain scoring charts in use. For medicines prescribed to be given covertly, there was no information for staff on how to administer these medicines, for example whether to crush a tablet or add it whole to people's food.

The provider sent us an improvement plan, setting out how they would address the breach. This included revising the medicines policy in line with current national medicines guidance (NICE Managing Medicines in Care Homes March 2014), cascading it to staff by 27 June 2015 and putting in place a more effective auditing system for medicines by 27 April 2015.

At this inspection we found that the aspects of medicines management which were being managed safely at the last inspection were still managed safely and most of the issues relating to the safe management of medicines we reported on our last inspection had been rectified.

Medicines requiring refrigeration were now stored at the correct temperatures, and were within their expiry dates. Prescribed creams were well managed. There were now topical medicines application records and body maps in place, to give care staff sufficient instructions on how to apply these creams, and to record when creams were applied. Accurate records were kept of the doses of medicines administered to people. Staff responsible for administering medicines had received more comprehensive medicines training and there were formal documented assessments of their competency to administer medicines. There was evidence that appropriate action was taken after medicines incidents, such as notifications, investigations and supervision for staff. Pain care plans were in place, and pain assessments were being carried out on a monthly basis for some people prescribed with pain relief, that ensured people's pain relief was being well managed.

However, the process for covert administration was still unsafe. One person had continued to be placed at risk of unsafe medicines administration since our last inspection. Two members of staff told us that they were crushing tablets before administering them covertly to one person, in their food. The service provided us with evidence that the GP had given authorisation for these medicines to be crushed. When we looked at this person's medicine administration record, three of the medicines being crushed were clearly labelled "Swallow this whole. Do not crush or chew". These were modified release medicines, intended to be swallowed whole, and released slowly throughout the day. By crushing the tablets, this person was placed at risk of adverse effects as they would have received the entire dose at the same time.

Although a mental capacity assessment had been carried out, which determined that the person did not have capacity to make decisions, it did not mention medicines specifically. There was also no evidence that a best interests meeting had been held to discuss and document the reason for covert administration. Staff told us that they had not sought approval from the pharmacist regarding whether it was safe to crush these tablets. The revised covert administration policy included a template which required both the GP and the pharmacist to give their approval, but this policy had not been implemented in June 2015 when the provider told us it would have been.

The day after the our inspection, the provider sent us written confirmation that they were no longer crushing tablets for this person, and that they were going to seek advice from the GP and pharmacist regarding a safe method of covert administration.

In addition, protocols were still not in place for medicines prescribed to be given as needed or "PRN", so there was no

Requires improvement

Is the service safe?

information for staff on whether someone was able to request their PRN medicine or whether staff had to carry out an assessment to determine whether to administer a dose. The operations and clinical support manager told us that there were plans to implement the PRN protocols in the next month and they confirmed to us in writing that they had begun implementing the protocols the day after our inspection.

We noted one new issue, that when people were being supported to self-administer some of their medicines, mainly creams, this had not been risk-assessed, as required by the home's revised medicines policy, to determine whether people were able to do this safely. Although it had not been risk-assessed initially, staff were carrying out weekly checks to make sure that people were continuing to self-administer safely.

The manager carried out weekly medicines audits, and the operations and clinical support manager carried out a more comprehensive monthly medicines audit. Improvements had been made on the audit of medicines since our last inspection. However, the audits did not identify the concerns we found during this inspection relating to unsafe covert administration and the lack of risk assessments for people that self administered medicines. The provider had been slow in implementing the revised medicines policy and make all the changes needed to ensure medicines were managed safely according to current national medicines guidance.

Therefore although improvements had been made, the provider was still in breach of the medicines regulation, Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). The provider must take further action to ensure that medicines are managed according to current national medicines guidance.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with the unsafe management of medicines. Regulation 12 (2) (g)