Tameng Care Limited

Shawcross Care Home

Inspection report

Bolton Road
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Shawcross Care Home is located in Ashton in Makerfield and provides residential and nursing care. The home is divided into two separate units, one for nursing care and one for people living with a diagnosis of dementia; which the home refer to as the EMI unit, each providing accommodation over two floors. The home provides single occupancy rooms with private toilet facilities and can accommodate up to 50 people.

This unannounced focussed inspection took place on Wednesday 19 July 2017. A full comprehensive inspection was last carried out at the home on 20 and 22 March 2017, when we rated the service as 'requires improvement' overall with two breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to safe care and treatment in the management of medicines and good governance. The full comprehensive report from this inspection can be found on our website at www.cqc.org.uk/location/1-130725445.

During the last comprehensive inspection we identified the home had made significant progress since the previous comprehensive inspection in August 2015. As a result of identified progress between inspection and the fact positive action was taken between the first and second days of inspection to address concerns identified, including the production of a detailed action plan, we undertook this focussed inspection to re-look at the areas of medicines management and good governance, specifically medicines audits, to confirm the service now met legal requirements. This report only covers our findings in relation to these two areas, which fall under the 'Safe' and 'Well-led' key questions.

At the time of the inspection the home had a registered manager. 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.

During this inspection we saw all issues with medicines management identified at the previous comprehensive inspection had been addressed. New systems and procedures had been in place for the last four months including a new process for monitoring and recording the ordering and receipt of medicines. This ensured medicines had been ordered in good time.

Daily monitoring of medicines fridges had been completed, utilising new recording sheets which prompted staff to reset the thermometer each time, to ensure subsequent recordings were accurate.

A new system was in place for monitoring the use of transdermal patches; which are medicated adhesive patches placed on the skin to deliver a specific dose of medication through the skin and into the bloodstream, to ensure they had been applied to a different area of the body as per guidance and only one patch was in situ at any one time, to avoid the potential for overdosing.

Procedures and guidance was in place for managing the administration of medicines which are more

effective if given before breakfast or on specific day. Where it had not been possible to administer the medicines before breakfast, staff had waited an hour after the person had eaten before administering. The use of inhalers and blood glucose monitoring had been reviewed, with monitoring charts in place and guidance sought from the person's general practitioner (GP), which was clearly detailed in the care files.

The home had a range of systems and procedures in place to monitor the quality and effectiveness of medicines management. Audits were completed on a daily, weekly and monthly basis and covered a range of areas including completion of Medicine Administration Record (MAR) charts, stock level checks, topical medicines, ordering and receipt of medicines and record keeping. We saw action plans had been drawn up and implemented to address any identified issues, and our observations during the inspection showed issues had either been addressed in full or where in the process of being addressed, such as a medicine related reference book had been ordered but not yet received.

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.

New systems and processes had been introduced to ensure medicines were managed and administered safely and effectively.

Is the service well-led?

Good

The service was well-led.

Audits and monitoring tools were in place and used regularly to assess the quality and effectiveness of medicines management. We saw evidence of issues being identified and addressed as a result of these systems and processes.

Shawcross 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.

The focussed inspection took place on 19 July 2017 and was unannounced. This inspection was undertaken to ensure improvements to meet legal requirements planned by the provider after our inspection on the 20 and 22 March 2017 had been made. We inspected the service against two of the five questions we ask about service; is the service safe? And is the service well-led? This is because the service was not meeting some legal requirements.

The inspection team consisted of one adult social care inspectors from the Care Quality Commission (CQC).

Before commencing the inspection we looked at any information we held about the service, including the action plan sent to us after the inspection. We had also met with the registered manager on 19 May 2017 to discuss the comprehensive inspection, subsequent report and actions taken by the service to make improvements.

During the course of the inspection we spoke to one nurse and one senior carer. We looked at 10 Medication Administration Record (MAR) charts, other medicine related documentation, including daily, weekly and month audits and completed stock checks of eight people's medicines.

Good

Is the service safe?

Our findings

At the last comprehensive inspection on 20 and 22 March 2017, we saw transdermal patch administration sheets were not completed consistently which would impact on staff's ability to apply these to a different area each time as required. Daily monitoring of the medicines fridge to ensure the temperature was between the normal limits of 2 and 8 degrees had not been completed properly. The temperature gauge had not been reset after each use, as required, which meant the recordings for the last three months were incorrect. Stock balance checks and re-ordering of medication processes were not working hand in hand. We saw there had been at least four incidents over the current month where medication had either been missing or would be missing within the next 24 hours. We noted no consistency in the administration of medicines which are more effective if given before breakfast or on specific day. Some people had these medicines given to them by the night staff, whilst others were given them with the rest of their morning medicines. Monitoring of self-administered medicines such as inhalers was not in place; with staff only seeking verbal confirmation these had been taken and monitoring was also not in place for staff to document blood glucose readings and ensure daily testing was completed.

This was a breach of regulation 12(2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider did not ensure the proper and safe management of medicines.

During the focussed inspection we found the provider was now compliant with this regulation. We saw daily a procedure and guidance was in place regarding site checks for transdermal patches. The new system, which was used in conjunction with administration sheets, ensured patches were checked daily and their location documented, to ensure subsequent patches were applied to a different area. We looked at administration sheets for two people and noted these had been completed consistently, as had the new monitoring system.

New fridge temperature monitoring sheets had been put in place, which included the recording of minimum, maximum and current temperatures along with a reminder to re-set the gauge. Guidance to both remind and support staff to complete this process had been put up either on or next to the medicines fridges. We checked the data for the last two months and saw records included all necessary information.

The home had implemented a 'medication chasing book' to document all steps and actions taken regarding the ordering of medicines. The book had been divided into sections which included the person using the service's name, confirmation the request for medicines had been submitted, date of submission and signature of staff member making the request and the date medicines actually received. We also noted each entry included a prompt to check if medicines had been received by a specific date, to allow enough time for chasing up outstanding requests, to ensure medicines where in place before current stock ran out. We saw this system was working effectively with only one issue noted, when the home had requested one person's inhaler in plenty of time as well as chasing up the prescription, however the medicine had still only been delivered the day after it was actually required.

Following the comprehensive inspection, the home had sought guidance from the local Clinical

Commissioning Group (CCG) regarding the administration of medicines which are more effective if given before breakfast or on specific day. The guidance received was that it was preferable to administer such medicines later than prescribed, rather than not at all. With this is mind, the service had implemented guidance, which staff spoken with were aware of, to wait up to an hour following meals and administer the medicine at that time, if they had not managed to administer before the person had eaten breakfast. We also saw an early morning medicines sheet had been put in place, detailing the names of all people who had early morning medicines to act as a prompt for staff. On the Medicine Administration Record (MAR) charts we looked at, we saw a number of occasions when medicines prescribed to be given before breakfast had been given later. In each instance the reason for doing so had been recorded on the rear of the sheet and tended to be due to the person being asleep. Whilst staff confirmed the new guidance had been followed and the medicine given an hour after eating, we noted the actual time of administration had not been recorded on the MAR chart to evidence this. The registered manager agreed this would be best practice and agreed to implement following the inspection.

When reviewing MAR charts, we noted guidance had been put in place for one person who took a medicine prescribed to be given early morning, to be given it later on Monday's, as they also took an additional medicine early morning every week on Monday, and there needed to be a two hour gap between both medicines in order for them to be effective. This evidenced good care and safe practice.

We looked at the management of inhalers and recording of usage. We saw all inhalers on the EMI unit had been administered by staff, and documented on MAR charts. On the nursing unit, only two people used inhalers and we saw monitoring sheets were in place. Although one of the people self-administered their inhaler each morning, they were observed doing so by a staff member to confirm it had been taken. In regards to the documenting of blood glucose readings, for the only person this was relevant for, we saw GP guidance was in place which indicated that due to having Type 2 diabetes, the person did not need regular blood glucose checks completing, however due to taking a hypo-glycaemic medicine, to carry out checks if the person was unwell or appeared drowsy. A monitoring sheet was in place for this purpose and had been completed sporadically, when staff had been concerned about the person's presentation, however readings had been with acceptable levels.

Based on the evidence seen during the focussed inspection we reviewed the rating for this key question. As the only issues noted during the comprehensive inspection within the 'safe' question related to medicines management, and all issues had been addressed and the service was now compliant with the regulations we have improved the rating to 'good'.

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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 the last comprehensive inspection on 20 and 22 March 2017, we found the home used a range of systems to assess the quality of the service. Despite the comprehensive auditing systems in place, we saw none of the issues noted with medicines management, such as temperature recording or stock control and ordering had been identified as part of these processes. This was a breach of Regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider did not effectively assess, monitor and improve the quality of the service as systems and processes did not identify where quality and/or safety were being compromised and respond appropriately.

During this focussed inspection we looked only at systems and processes in place to monitor and audit the safety and quality of medicines management, as auditing systems for all other areas were found to be robust during the comprehensive inspection.

We saw both the EMI and nursing units had daily and weekly medicines audits in place. These included a 10 point daily MAR check which involved monitoring when the medicines round had started and ended, ensuring all medicines had been administered and signed for and the MAR chart had been completed correctly. On overview of the same information was completed on a weekly basis. Alongside this we also saw evidence of the daily auditing of five different people's medicines to ensure the MAR was correct, stock levels were accurate and all other documentation was in place and up to date.

The home also completed weekly audits of topical medicines, such as creams and lotions. This ensured these types of medicines had been administered correctly and the charts in place to document their usage completed accurately.

A daily walk round was carried out by the registered manager to check on a number of areas, such as cleanliness, quality of care but also included spot checks of medicines management, completion of documentation and the audits in place.

Each month the registered manager completed a monthly medicines audit, as part of a range of quality assurance information required by the provider. We saw the audit covered all areas of medicines management including; fridge temperature recordings, ordering and receipt of medicines, record keeping, training and medicines auditing processes. We looked at the last two months audits and noted a number of minor issues had been identified, along with the generation of an action plan for addressing the areas noted. Upon completion of the audit, any action plans had to be submitted to the regional manager within 24 hours. We spoke to the regional manager as part of the focussed inspection, who confirmed this process was adhered to each month.

Two of the areas identified during the June 2017 audit, was the date of opening had not been consistently recorded on all new medicines and weekly topical medicines audits had not been done consistently. During the inspection all boxed and topical medicines we checked contained a date of opening and we saw evidence topical medicines audits were in place and being completed.

Based on the evidence seen during the focussed inspection we reviewed the rating for this key question. The only issue noted during the comprehensive inspection within the 'well-led' question related to auditing systems not identifying the issues we found. We saw these issues had been addressed and the service was now compliant with the regulations, as a result we have improved the rating to 'good'.