Caring Consultancy Limited

Whitefriars Nursing and Residential Home

Inspection report

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Tel: 02085740156

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19 September 2017

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Ratings

Overall rating for this service	Good

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**

Summary of findings

Overall summary

This focused inspection took place on 19 September 2017 at 8.45pm and was unannounced. The inspection was prompted by allegations that procedures for the safe management of medicines were not being followed, that people were not always being referred for healthcare input in a timely way and that staff slept on duty at night.

Previously we carried out a focused inspection on 17 February 2017 at 10.30pm due to an allegation that people were being locked in their rooms, and found this allegation to be unsubstantiated. The last comprehensive inspection was on 28 April 2016 when we rated the service 'Good' for all of the five questions we ask about services and Good overall. There were no breaches of the Regulations at our last two inspections.

Whitefriars Nursing and Residential Home provides accommodation and nursing care for up to 28 older men and women. The provider is also registered to provide personal care to people living in their own homes but this service was not operating when we carried out this inspection.

The provider's Nominated Individual is also the 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 the inspection, we found that some aspects of the management of medicines were not being carried out safely. Staff did not always adhere to the provider's medicines policy in relation to the administration of medicines and writing out protocols to administer medicines to be given as required to people. Staff had also not noted on one occasion that the medicine being administered to one person was not the usual dose for an adult and that the dose and instructions on the medicine label did not match the hospital discharge letter. As a result there were risks that people might not receive their medicines in a safe manner.

Risks people faced whilst receiving care were generally well managed. In a few instances, we found that risks management plans were not comprehensive in mitigating identified risks.

We found a breach of regulation in regards to safe care and treatment. You can see what action we have asked the provider to take at the back of this report.

People received the support they needed to meet their healthcare needs. Staff ensured the relevant healthcare professionals were contacted for advice and to visit people to ensure they received healthcare they needed. We noted that people's care records were not always updated to reflect the support they received and the outcomes of the referrals. The registered manager said they would improve this when we discussed this with them.

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

Some aspects of the service were not safe.

Staff did not always adhere to the provider's medicines policy to ensure people received their medicines safely.

Whist overall risks people faced whilst receiving care were managed safely we found a few instances where risks assessments were not as comprehensive as they could have been.

We have changed the rating for this key question from 'Good' to 'Requires Improvement'

Is the service effective?

Good

The service was effective.

People received the support they needed to ensure their healthcare needs were met. However, their care records were not always updated to reflect this. The registered manager told us they would improve this.

We have maintained the rating for this key question as 'Good'.

Whitefriars Nursing and 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.

The inspection was prompted by allegations that administration procedures for medicines were not being followed, that people were not always being referred for healthcare input in a timely way and that staff slept on duty at night.

This inspection took place on 19 September 2017 and was unannounced.

The inspection was carried out by two inspectors. Before the inspection we reviewed the information we had received about the service since the last inspection. These included information we had received from the local authority and notifications from the provider. A notification is information about an incident or an event that has occurred within the service that the provider has to notify CQC by law.

During the inspection we carried out a tour of the premises and spoke with all the staff on duty, those being a registered nurse and two healthcare assistants. We viewed care records for four people, looking at specific elements of their care plans and assessments and the medicines records for five people. Following the inspection we spoke with the provider and the local authority.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from the risks that can arise if medicines are not managed appropriately. We found that overall medicines administration records (MAR) were completed appropriately when medicines were received in the home or when medicines were administered. There was at least one occasion when the actual amount of a medicine, prescribed to be given as a variable dose, was not recorded when administered.

Where medicines were prescribed to be given as required (PRN), we found forms to record the protocols to administer the medicines, were in place. However, these were not completed appropriately to clearly indicate when and the circumstances in which the medicines should be given or repeated. For example a medicine prescribed to be given for constipation did not make clear after how many days to give the medicine, what to do if the medicine did not work and how often should the medicine be repeated. Another person prescribed a variable dose of a PRN medicine had a protocol in place, but this did not make clear when one or two of the tablets should be given. The provider's medicines policy states "Clear instructions must be obtained from the prescriber as to indications for the medication and what circumstances it may be administered. Following administration of PRN medication the outcome for the resident should be noted and monitored in order to from a comprehensive picture of care and support future consultation with the prescriber." We did not find that this section of the policy was being adhered to.

On one occasion a person was discharged from hospital with a medicine to treat a specific condition. We saw that the strength and instructions to administer the medicine on the hospital discharge letter differed from the strength and instructions on the medicine label. We also noted that the amount of the medicine the person was receiving was much smaller than the recommended dose for an adult. Staff administering the medicine had not noted this discrepancy even though several doses of the medicine had been administered to the person by different staff. When we reported our concerns to the registered manager they took prompt action and the amount of this medicine was reviewed by a doctor who increased the dose to suit the person's needs. We have also reported this incident to the local authority safeguarding adults team.

We asked the night staff how they administered medicines for people who lived on the first or the second floor. They explained that they prepared the medicines for the two people on the second floor in individual pots, placed the two pots that contained the people's medicines on a tray and took the tray upstairs to administer the medicines. They explained that the medicines trolley was not easy to take to the upper floors in the lift. The provider's medicines policy states that medicines should be administered to one person at a time. It is also well documented in the Nursing and Midwifery (NMC) guidance on the management of medicines that medicines should also be administered to one person at a time to prevent the risk of errors. This therefore meant that staff were not always following the provider's policy and NMC guidance on the administration of medicines.

We briefly looked at the risk assessments in place to manage risks to people whilst they received care and treatment in the service. These were overall appropriately completed but in a few cases were not as

comprehensive as they could have been. For example where a person's medicines were crushed before administration we did not see a comprehensive risk assessment in place that had been agreed by healthcare professionals including the pharmacist.

Where people were at risk of developing pressure ulcers or had pressure ulcers, we saw appropriate risks assessments in place to mitigate the risks. These included completing turning charts and providing pressure relieving equipment. We noted that the system in place to check that pressure relieving equipment was working appropriately was not consistently used. Whilst staff confirmed they were checking the equipment, there were no regular records of when the equipment was checked.

The above shows that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we asked staff if there were enough of them on duty, they confirmed there were enough staff on night duty and they did not need to rush. They said they did not need to use agency staff as if there was a shortage other staff were rostered to cover. We observed that people were not rushed and staff allowed people time to do the things they wanted. People could stay up as long as they wanted and we saw that at least eight people were up when we started our inspection.

We spoke with all the staff on duty about what they do on night duty. They all confirmed the various rounds they completed and how breaks were staggered so that there were always two staff available to provide any care and support people required. The staff were very clear that sleeping on duty was unacceptable and said they had not experienced anyone do this, however they said if they had any such concerns they would report them to the provider. Staff said they had completed safeguarding training and were clear to report any concerns. They also said that if the provider did not take action they would report to the Care Quality Commission or to social services, in line with whistleblowing procedures.

Staff were knowledgeable about people's individual care needs and how to care for them at night and in the morning. They were clear that people were only helped to get up if they woke up early of if the person wanted to.

Good

Is the service effective?

Our findings

People were appropriately supported by staff to meet their healthcare needs. We noted that staff had identified circumstances when people needed to be referred to healthcare professionals and they have done so in a timely way. For example we saw a person was regularly reviewed by a speech therapist when they had difficulty to swallow and speak. The GP visited the service weekly to review people who were referred to them. Where the GP or other healthcare professionals had prescribed treatment or given instructions about how to support people with their healthcare needs, staff followed the instructions to carry out any treatment ordered. Although the instructions from the GP and other healthcare professionals were included in the care files and staff were able to tell us about the care and treatment people had received, the care plans did not reflect this.

When we spoke with the provider after the inspection they told us that they had arranged a meeting with all the registered nurses to discuss the issues raised at the inspection. They said that as part of this all the care records would be reviewed to ensure the care plans were up to date and accurately reflected the treatment people were receiving.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider did not have effective arrangements to ensure people were always protected against the risks associated with the management of medicines. They have not always ensured that risks were appropriately assessed and action taken to mitigate identified risks. Reg 12 (1)(2)(a)(b)(g)