Affectionate Care Home Limited

Ersham House Nursing Home

Inspection report

Ersham Road
Hailsham
BN27 3PN

Tel: 01323442727

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19 July 2021

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16 August 2021

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

Ersham House Nursing Home is a care home with nursing and accommodates up to 40 people in a purpose-built building. The service supports adults whose primary needs are nursing care. Some people also live with additional mental health conditions, and dementia. At the time of our inspection there were 24 people living at the service.

People's experience of using this service and what we found:
This was a targeted inspection that considered the management of medicines. Based on our inspection we found that areas of medicine management were not safe. Risk of harm to people had not always been mitigated as good practice guidelines for the management of medicines had not been followed.

Following the inspection we received an action plan and confirmation of involvement of the medicine optimisation in care homes (MOCH) team to mitigate risk.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection:
The last rating for this service was Requires Improvement (published 12 June 2021).

Why we inspected:
The inspection was prompted in part due to concerns received about the management of medicines. A decision was made for us to inspect and examine those risks.

Enforcement:
We have identified a continued breach of Regulation in relation to safe care and treatment regarding the management of medicines.
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question Requires Improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Ersham House Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This was a targeted inspection due to concerns we had about the safe management of medicines.

Inspection team
The inspection team consisted of two inspectors.

Service and service type
Ersham House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed the information, we held about the service and the service provider. We sought feedback from the local authority, safeguarding team and healthcare professionals that are involved with the service. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

During the inspection
We spoke with two people who used the service. We spoke with six members of staff, this included the manager, registered nurse and care staff. We reviewed a range of records. This included people's care medicine records, risk assessments and care plans,.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We received feedback following the inspection from four health and social care professionals.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The purpose of this inspection was to check a specific concern we had about medicines. We will assess all of the key question at the next comprehensive inspection of the service.

Using medicines safely

● We spoke with two people who told us "I think I get all I need, I do talk to staff about my pills and I can ask for pain tablets if I need them," and "Sometimes I have to wait."

● Medicines were not managed safely. Since the last inspection the management team had changed the provider of medicines due to concerns regarding delivery. They had changed from using the electronic VMAR system and transferred to paper medicine administration record (MAR) charts. This had created delays and confusion about delivery of essential medicines.

● MAR charts were not all completed in a safe way following national good practice guidance. For example, handwritten entries of medicines were not clearly written and signed by two staff members to ensure that it was correct: medicine dosages and instructions had been crossed out and changed, but these were not all initialled, double signed or dated.

● There were some signature gaps on the MAR's and there was no evidence that this had been followed up to ensure the medicine had been given. The signature list for staff who administer medicines was incomplete and signatures were difficult to track. One signature was the same as the code used by staff to indicate they had offered the medicine.

● We looked at the care plans and risk assessments for people prescribed short-term antibiotics for urinary infections. There was no update recorded to care plans and no reflection of actions taken to prevent a re-occurrence such as monitoring their fluid intake

● Medicines prescribed on an 'as and when required' basis (PRN) did not all have guidance and protocols which informed staff of when the medicines may be needed. For example, one person was prescribed a muscle relaxant but there was no guidance for staff to recognise when it may be required or if it had been effective. We also found 'just in case' medicines for symptom relief during a person's end of life care had no guidance available as to when it may be needed or pain charts in use to monitor their symptoms. This meant that people at this stage of their life may not get the medicines they require.

● Pain charts to monitor for effectiveness of pain relief to guide staff in seeking further advice from the GP or pain clinic were not routinely used.

● Topical creams had been prescribed for some people but there was no guidance on MAR charts of where the cream should be applied and no body chart for care staff to follow.

● One of the concerns was that people had not always received their prescribed medicine. Two of these are currently being investigated by the local authority as to the root cause. Systems however for ordering needed to be improved and monitored to ensure medicines were ordered in a timely way. Following the inspection the provider sent us the new medicine ordering policy and missing medication form that was now being used.

The provider had not ensured the safe The provider had not ensured the proper and safe management of medicines. management This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to their health and safety and doing all that is reasonably practicable to mitigate any such risks. The provider had not ensured the proper and safe management of medicines.