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# Willows Nursing Home

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

We carried out an unannounced comprehensive inspection of this service in April 2017. We found the home to be rated 'Requires improvement' and we found one breach of regulations regarding the way medicines were managed in the home.

We asked the provider to take action to address these concerns. After the comprehensive inspection, the provider wrote to us to tell us what they would do to meet legal requirements in relation to the breach.

We undertook a focused inspection on 28 September 2017 to check that they had they now met legal requirements. This report only covers our findings in relation to the specific area / breach of regulation. This report only covers two questions we normally asked of services; 'Is the service safe?' and 'Is the service Well led?'

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Willows Nursing Home' on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

The Willows Nursing Home provides accommodation for up to 28 people who require nursing care.

There was a new manager who had started in post in the last month; they were in the process of applying for registration with the Care Quality Commission [CQC]. A registered manager is a person who has registered with the CQC 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.

We found the service had made improvements to the way medicines were administered and managed; medication administration was safe. We found the breach had now been met.

The improvements related to previous areas of concern regarding the recording and storage of 'thickening agents' [to thicken drinks for people with swallowing difficulties] and application of external preparations such as creams.

We made a recommendation regarding the way applications of creams were recorded. There were other improvements to recording of medicine records also discussed.

## 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 fully safe.

We reviewed the management of medicines; we found improvements had been made. The service had met this requirement.

We made a recommendation regarding the way creams were recorded.

**Requires Improvement** ●

### Is the service well-led?

There was a new manager who had started in post; they were in the process of applying for registration with the Care Quality Commission [CQC].

Medication auditing processes were in place and were used regularly to identify medication issues and any further improvements needed. This was an improvement from the last inspection.

While improvements had been made we have not revised the rating for this key question. To improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for 'Well led' at the next comprehensive inspection.

**Requires Improvement** ●

# Willows 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 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.

This focused inspection took place on 28 September 2017 and was unannounced. The inspection team consisted of an adult social care inspector. We checked that improvements to meet legal requirements identified after our comprehensive inspection in April 2017, had been made.

We inspected the service against two of the five questions we ask about services; 'is the service safe'? And 'is the service well led'? This is because the service was not meeting legal requirements in relation these questions.

We looked at records in respect of the management of medicines including medicine administration sheets, staff training and support, people's plan of care and quality assurance processes and systems, including service audits.

We spoke with the nurse in charge [deputy manager] at the time of our inspection as well as a senior manager for the organisation and one of the providers [owners]. We also spoke with a visitor and three of the people living in the home and made some observations of care appertaining to medicine administration.

# Is the service safe?

## Our findings

We previously inspected this home in April 2017. We found the provider to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found medicines were not being managed safely. This was because:

We found creams for four people had been supplied. We were told these were administered daily by care staff. The administration records were kept in people's bedrooms for care staff to sign when they had applied / administered the cream; we found these had not been completed; there were numerous gaps in the records and we were not clear if the creams had been applied. Also some of the people living at the home were prescribed 'thickening' powder to thicken their drinks. This is to aid people who may have swallowing difficulties to accept fluids and reduce the risk of choking. The thickening powder is a prescribed medicine which needs to be stored safely. We found two examples of thickeners being left accessible in people's rooms and therefore presenting a safety risk. There was also a lack of detail on the record chart to indicate to staff how much thickening agent should be used.

We asked the provider to take action to address these concerns. The provider submitted a provider action report which told us the improvements they had made to meet this breach.

On this inspection we checked to make sure requirements had been met and we found improvements overall to medication management. The breach had been met.

On inspection we saw there were two people prescribed thickening agents to thicken their drinks. We found good, clear records for these people. There were good supporting documentation [care plan] in place and easily accessible for care staff to refer to when they were making up drinks for both people. The information stated which thickening agent to use and in what quantity. All drinks were recorded on a chart, including the required consistency, and signed by the care staff involved in giving the drink. This was a clear record and it could be seen thickeners were being given consistently and safely.

We saw both of the people who were prescribed the thickeners and found the containers of thickening powder were stored safely and not easily accessible for people who may be at risk of ingestion. We spoke briefly with a visitor and three people living at the Willows. They told us they received their medicines on time and could request tablets, such as painkillers, if they needed them. One person said, "Yes, they are very good; I always get my medicines."

We checked medication administration records for seven people. Some of these were prescribed creams to be applied. These were applied by staff. We found each person had a chart in place identifying the cream as prescribed on the medication administration record [MAR]. This chart detailed when and where the cream should be applied. The nurse carrying out the medication round recorded on the MAR, after checking with care staff, that the cream had been administered. There was no record however of which care staff had applied the cream. We discussed this omission in the current recording procedure.

We recommend a system of recording is in place to record the staff member who applies the cream.

Following the inspection the manager sent us a copy of a new recording chart for care staff to complete which we were told would be instigated immediately.

A medication policy was in place; this was inclusive of guidelines for covert administration of medicines. There were one person whose medication was being administered covertly; i.e. without their knowledge and in their best interest. We found this had been managed well with a robust care plan in place which clearly identified the risks and consideration of the consent issues involved. We found there had been appropriate liaison with health care professionals including the person's GP and family. A capacity assessment, specific to the decision, had been carried out to meet requirements under the Mental Capacity Act 2005.

We found medicines to be stored safely when not in use. Some medicines need to be stored under certain conditions, such as in a medicine fridge, which ensures their quality is maintained. If not stored at the correct temperature they may not work correctly. We saw the temperature of the drug fridge was recorded although daily records had been omitted since 23 September [four days]. On the day of our inspection the fridge temperature was recording safe storage.

Controlled Drugs [CD's] are prescription medicines that have controls in place under the Misuse of Drugs legislation. We saw there were arrangements were made for the storage of controlled drugs. There was a controlled drug register in evidence, for use if needed. We undertook a stock check of one of the CD's and found this to be correct.

We found that medicines that were given PRN [as required when necessary] were managed safely. There were clear protocols in place – PRN care plans – to help ensure that staff understood when the medicines were to be given. This helped ensure consistent administration.

Staff had signed MARs to say they had administered the medicines. Records were clear and we were able to track whether people had had their medicines. There was a photo identification of each person so that any errors of administration could be reduced. The nurse in charge [deputy manager] carrying out the medicines round had signed the MAR following the administration of each medicine. We spoke with the deputy manager who was knowledgeable regarding the times for certain medicines to be give; for example medicines to be given before or after food.

We found some recording issues with the medicines which we highlighted to the deputy manager. These included two MARs which were handwritten by staff because medicines had brought into the home mid cycle of routine pharmacy but had not been routinely signed, for good practice, by a second staff to check accuracy. Both of these were a true record when we checked. Also, some variable dose medicine did not have the dosage administered recorded on the MAR.

The home had a medication policy which was up to date and covered medication safety and areas of good practice.

## Is the service well-led?

### Our findings

Following our last inspection in April 2017 we identified the auditing processes regarding medication management needed improving. Existing audits had not been fully developed and had not identified the issues we had found in administration of medicines.

On this inspection we found the auditing process had been improved. We were given copies of the home's internal medication audits which covered four key areas; client medication audit [individual], controlled drugs (CD) audit, 'thickener' audit and topical creams audit. These were completed monthly. The audits seemed generally effective in identifying areas for improvement. For example, the auditing of individual MARs had picked up some recording errors and we saw action had been taken to address these with staff concerned. Some auditing was still not wholly effective; for example we saw the topical creams audit had failed to identify staff signatures following administration.

There was also a six monthly audit which had been undertaken by the operational manager recently and this covered all areas of medication management including safe storage. Overall the auditing processes for medicines had improved.

There was a new manager who had commenced at the home but was not present on the day of our inspection. The manager was not yet registered with the Care Quality Commission but was in the process of applying. On the day of the inspection we met and spoke with the deputy manager as well as the quality assurance manager for the provider. We found both managers receptive and open to the feedback we gave.

The deputy manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home.

From April 2015 it is a legal requirement for providers to display their CQC (Care Quality Commission) rating. 'The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided'. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for Willows Nursing Home was displayed for people to see.