Tamaris Healthcare (England) Limited

Maple Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

The last inspection of Maple Lodge Care Home was carried out in May 2016. At that inspection we found the provider had breached regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have accurate records to support and evidence the safe administration of 'as required' medicines and prescribed creams. We carried out this unannounced focused inspection on 8 December 2016 to check whether the provider had made improvements to the way medicines were managed.

Maple Lodge is a care home which provides nursing and personal care for up to 46 people, some of whom may be living with dementia. There were 44 people living there at the time of our inspection.

There was a registered manager in place at the service who had been in that role for several years. 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.

We found the service had made improvements to the way medicines were managed.

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

The service was safe.

We found that action had been taken to improve the records and guidance about people's 'as required' medicines.

While improvements had been made we could not improve the rating for Safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Maple Lodge 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.

This unannounced focused inspection took place on 8 December 2016. The inspection was undertaken to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection in May 2016 had been made. We inspected the service against one of the five questions we ask about services: Is the service safe? This is because at the last inspection the service was not meeting a legal requirement in relation to that question.

The inspection was undertaken by one adult social care inspector.

Before our inspection we reviewed information we held about the service and the provider such as the action plan the provider submitted setting out how they would become compliant with the breach identified at the previous inspection.

During our inspection we looked in detail at the medicines records for twelve people, medicines storage and the provider's medicines policy and procedures. We spoke with the registered manager and two nurses.

Inspected but not rated

Is the service safe?

Our findings

At the last inspection in May 2016 the service was not always managing people's medicines in a safe way. People's care plans and medicine records lacked guidance for staff relating to 'as required' medicines. For example, several people were prescribed pain relief such as paracetamol 'as required', but there was no guidance for staff about how people might show they required pain relief, such as verbally or exhibiting other signs of pain.

During this inspection we saw there was now guidance about each person's 'as required' medicines in the medicines file. This meant staff could ascertain if people wanted or required that medicine. For example, one person was not able to say if they needed their pain relieving medicine. The guidance for staff described how the person might present if they were in pain, including grinding their teeth or grimacing.

Where people had been given any 'as required' medicines these were recorded on a separate report to show the time it was given, the reason it was given and the quantity (for example whether one or two paracetamols). This meant there was a clear account of the number of times people needed their 'as required' medicines and whether any further action was required. For instance, one person had needed pain relief three times a day for some days so the nurse was contacting the person's GP for a review of their medicines to see if they needed this permanently now.

At the last inspection we saw 'X' had been recorded on medicine administration records (MARs) when medicines that weren't prescribed daily weren't to be administered, but this was not a standard or correct code for the type of MAR used at this service. This meant accurate records were not always kept when medicines were not administered. During this inspection we saw staff no longer used this incorrect code.

At the last inspection we saw some handwritten instructions on medicines records which had only been signed by one staff member instead of two and there was no record of who had authorised the changes. Handwritten entries should be checked and signed by a second trained staff member in line with the National Institute for Health and Care Excellence (NICE) guidelines. During this inspection we did not see any handwritten instructions on medicines records.

At the last inspection we found the temperature of one treatment room where medicines were stored was exceeding the safe temperature limit, that is over 25°C. During this inspection we found the provider had installed an air-conditioning unit which made sure the room was kept cool. We saw records of the temperature checks each day showed medicines were now stored well within safe ambient temperatures.

While improvements had been made we could not improve the rating for safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

During this inspection we did note staff were using the code N to show when 'as required' medicines (also known as PRN medicines) were not needed or given. The code N stands for 'offered but refused'. This code is

not required to be recorded when 'as required' medicines are not given. Although this practice was not unsafe, it was contrary to the provider's own medicines policy, dated June 2016, which stated: 'If a Person does not request their PRN medication/does not need it after asking/or does not need it after assessing, then the medicines administration records is left blank. PRN medication is only signed for when it is administered.' The registered manager acknowledged this point and stated it would be communicated to all nursing staff through memos and individual supervisions.