Marantomark Limited

St George's Nursing Home (Oldham)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

St George's Nursing Home is a purpose built nursing home which provides nursing and personal care for up to 77 adults. It is divided into six units, caring for people living with dementia, older adults, younger adults, people with physical disabilities and mental health needs.

We carried out an unannounced comprehensive inspection of this service on the 4 and 5 October 2016. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment and good governance. We took enforcement action against the provider and issued Warning Notices and asked them to make improvements to the service.

We undertook this unannounced focused inspection on 2 and 3 February 2017 to check that they had followed their plan and to confirm that they now met legal requirements. We had also received a notification of an incident at the home involving a person who used the service. The information shared with CQC about the incident indicated potential concerns about the management of risk around the use of bed rails. As part of this inspection we examined those risks. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk.

At the time of this inspection there was a registered manager in post who had registered with the Care Quality in June 2016. 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 identified that the registered provider had not notified the Care Quality Commission of an incident that had resulted in a person sustaining a serious injury. The registered provider has a legal responsibility to inform the CQC of notifiable incidents. Failure to notify the CQC of this incident was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We found that although some improvements had been made in relation to the concerns we identified in October 2016, these had not yet been fully rectified. In addition, at this inspection we identified concerns around risk assessments, in particular that the provider was not completing bed rail risk assessments.

We identified there were continuing breaches of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment and Good Governance. These were in relation to medicines management and lack of appropriate risk assessments; and failure to monitor the quality and safety of the service. You can see what action we told the provider to take at the back of the full version of the report. We are currently considering our options in relation to enforcement in relation to

some of the breaches of regulations identified. We will update the section at the back of the inspection report once any enforcement work has concluded.

At our inspection in October 2016 we found shortfalls in the administration of medicines as policies and procedures for the safe storage, administration and recording of medicines were not always followed. At this inspection we found that although some improvements had been made, there continued to be problems with the safe administration and storage of medicines.

At our inspection in October 2016 we identified that hazardous substances such as fluid thickening agents were not stored securely. At this inspection we found this concern had been rectified and all hazardous substances were safely stored out of reach of people who used the service.

During our inspection in October 2016 we identified problems with the cleanliness of some areas of the home, and of equipment. We also found that personal toiletries were left in bathrooms. During this inspection we saw that although there had been some improvement in cleanliness we still found some areas in the home that were not cleaned to a high standard. For example the carpets in the lounges of Brook and Beal units were dirty and stained. The registered manager told us that she was looking into purchasing a carpet cleaner for the home, and that there was an ongoing programme of carpet replacement for the bedroom carpets.

We found that not all the people who used the service who required bed rail risk assessments had them in place. We had identified this issue prior to our inspection and during our inspection we found that the provider had started to implement bed rail risk assessments for all people who used bed rails within the home. However, at the time of our inspection this was not yet complete.

At our inspection in October 2016 we found shortfalls in some aspects of the management of the service, as systems for monitoring the quality and safety of the service were not sufficiently robust to identify some of the concerns we found during that inspection. At this inspection we found that although the provider had made some improvements there continued to be problems around safe administration of medicines, managing risk, cleanliness and monitoring the quality of the service.

The overall rating for this service is 'Requires improvement', however the service has been rated "Inadequate" in a key question and will be re-inspected within six months. If there remains an inadequate rating after six months, in any key question the service will go into special measures

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

The storage and administration of medicines was not always carried out safely.

There were not always adequate risk assessments in place to ensure the risks to people's health and welfare were identified and managed.

Some areas of the home were not cleaned to an acceptable standard.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Some concerns we identified at our previous inspection in October 2016 had been rectified. However, there were on-going concerns in relation to medicines management, lack of risk assessments, cleanliness and monitoring the quality of the service.

St George's Nursing Home (Oldham)

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.

We undertook an unannounced focused inspection of St George's Nursing home on 2 and 3 February 2017. The inspection was undertaken partly in response to information received regarding a specific incident during which a person using the service sustained a serious injury. At this inspection we also checked whether the provider had made improvements needed to meet the legal requirements following our comprehensive inspection on 4 and 5 October 2016.

At this inspection 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 was because we found the service was not meeting legal requirements in relation to some of these areas during our inspection on 4 and 5 October 2016.

On 2 February 2017 the inspection team consisted of an adult social care inspection manager, an adult social care inspector and a pharmacist inspector. On 3 February 2017 the inspection was carried out by an adult social care inspector.

Before our inspection we reviewed the information we held about the service; this included the inspection report from our inspection on 4 and 5 October 2016 and the provider's action plan which set out the action they would take to rectify the breaches of the regulations we previously identified. We reviewed the notifications the CQC had received from the provider. Notifications are changes, events and incidents the provider is legally obliged to send us without delay. We also reviewed information we had received from the NHS Clinical Commissioning Group about their concerns around lack of bed rail risk assessments.

During our inspection we spoke with the registered manager and reviewed care records, risk assessments, quality monitoring tools and other information which helped us assess whether or not the service was safe and well-led.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection of St George's Nursing Home on 4 and 5 October 2016 we found that people were not protected against the risks associated with medicines. This was because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our focused inspection on 2 and 3 February, 2016 we found the required improvements had not been made in full and there was a continued breach of this regulation.

We visited Haven and Brookdale units to see if medicines were managed safely. Medicines were kept safely to protect people from harm. We watched nurses giving people their medicines on both units and saw that the nurses were kind and patient when supporting people to take their medicines. On one occasion the nurse did not sign the medication administration record (MAR) immediately after administration and in another instance medicines were left unlabelled in 'pots' as the person was not ready to take their medicines. These practices increase the chance of an administration error if the nurse is distracted. We saw that one person who was prescribed a medicine that they needed to take at exact times, to get the most benefit from the medicine, was given their lunchtime dose one hour late.

We looked at the MARs belonging to 10 out of 21 people and saw two 'gaps' in the records of administration. A weekly audit was carried out to check that MARs were being completed correctly and we saw that missing signatures were noted and action taken. We counted the remaining stock of one person's antibiotic therapy and found that it had been administered correctly. However, a dose of another person's medicine had been signed as given when the home's records indicated that the medicine was unavailable on that day. This meant we could not sure the person had received their medication as prescribed.

We looked a five people's records in more detail. Two people had been visited by their GP and had been given a 'flu' vaccination: this important information about their care was not recorded in their care plans. Another person was prescribed a medicine for their heart and nurses were checking their heart rate each day. The medicine was not being given, but there was no explanation for this in the nurses' handover notes or in the person's care plan. There were no recorded instructions from the person's doctor to say if (and when) the medicine should be withheld. This meant the person might not be receiving the right treatment.

One person was prescribed a medicated cream to be applied twice a day. Their MAR showed that the cream had only been applied in the mornings. Another person was prescribed an anti-fungal cream to be applied twice a day. The record showed that over the previous eleven days the cream had been used a prescribed on three days, only once on seven days and not at all on one day. If creams are not applied as often as they are prescribed they will be less effective.

Medicines, including creams and thickening agents were stored safely. At our inspection in October 2016 we found that food thickening agents were not always stored safely and were accessible to people who used the service. A patient safety alert was raised by NHS England in February 2015 about the risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder. At this inspection we found this issue

had been rectified.

Medicine storage rooms were clean. However, medicines were not kept at the correct temperatures. The temperature in two medicine storage rooms we visited was 26 degrees Celsius (one degree above the maximum recommended by manufacturers for most medicines) and the temperature in a third room was not monitored. The temperature of one medicines refrigerator was only recorded on sixteen days in January and there were no minimum and maximum temperature readings. Minimum and maximum temperature readings tell staff whether refrigerated medicines have been at a safe temperature throughout the last 24 hours. Records for a second fridge stated that the temperature had consistently been below the minimum temperature for safe storage. If medicines are stored at the wrong temperature they can lose their potency and become ineffective.

On one unit we looked at the management of medicines that are controlled drugs. These are medicines that are subject to tighter legal controls because of the risk of misuse. We found that controlled drugs were stored and recorded in the way required by law and stock balances of the six controlled drugs we checked were correct. However, one bottle of a controlled drug in liquid form had not been dated when the bottle was first opened. This medicine has a shelf life of three months once the bottle has been opened. Therefore, unless the medicine has been dispensed with the previous three months staff cannot tell whether it should have been discarded. Giving out-of-date medicines may put people at risk of harm.

This meant there was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

At our inspection on 4 and 5 October 2016 we identified that the cleanliness of rooms and equipment varied between units and that some areas of the home were found to be dirty. We also found toiletries and tubes of opened toothpaste with no name, which meant that staff could not be sure which personal toiletries, belonged to individual people, or suggested that supplies were being used communally. At this inspection we again found problems with cleanliness and personal toiletries being left in bathrooms. On Manor unit was saw that two tubes of barrier cream, an electric razor and a hair brush had been left in one of the bathrooms. This meant we could not be sure these items were not being used communally, which would pose an infection control risk to people who used them.

On Grange unit some of the chairs in the communal area were ripped. On both Brook and Grange units we saw that the carpets in the communal areas were dirty and stained. The registered manager told us they were considering buying a carpet cleaner and had recently obtained quotes for the purchase. There was also a programme of gradually replacing carpet with washable flooring.

During our inspection we looked at the records of a person who had sustained an injury following a fall from a shower chair. This person had a risk management plan in place which stated that, due to a medical condition, they were at risk of falling out of bed. However, the provider had not identified that there was also a risk the person might fall from the shower chair and injure themselves, which they subsequently did. We are looking into this matter further. The registered provider had failed to notify the Care Quality Commission about this incident, which they are legally obliged to do. This is discussed further in the 'Well-Led' domain of this report.

Prior to this inspection we had received a notification of an incident at the home involving a person who used the service. The information shared with us indicated potential concerns about the management of risk around the use of bed rails. As part of this inspection we examined those risks. We reviewed people's risk assessments and care plans to check they contained sufficient information to enable staff to care for them

safely. During this inspection we checked if the home had a 'bed rails' policy, which it did. However, staff were not following it correctly, as they were not carrying out the required bed rail assessments. At the time of our inspection there were 35 people living at the home who had bed rails in place. Guidance produced by The Health and Safety Executive (HSE) advises that 'a risk assessment is carried out by a competent person taking into account the bed occupant, the bed, mattresses, bed rails and all associated equipment'. This is because one of the risks associated with the use of bed rails is the entrapment of the head and limbs, which can become trapped in gaps between the bed rails, or between the bed rail and the bed, headboard or mattress. Because no bedrail assessments were in place we could not be sure that it was safe for people to use bed rails.

Lack of appropriate risk assessments was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Requires Improvement

Is the service well-led?

Our findings

Following our inspection in October 2016 and the breaches identified in regulation 12, safe care and treatment and regulation 17, good governance we issued Warning Notices

We asked the provider to submit an action plan giving details of what improvements they would make to ensure the quality and safety of the service. At this inspection we saw that some improvements had been made. However, we identified continuing concerns in relation to medicines management and cleanliness. In addition, we identified new issues with regard to the lack of risk assessments, and in particular, to the lack of bed rail risk assessments. These concerns are discussed in the 'safe' key question of this report.

Following our inspection in October 2016, the provider took a number of steps to inform staff of the concerns we had identified, including issuing memos and instructions and through regular nurse management meetings. During this inspection we looked at the minutes for these meetings and saw that all the concerns raised during our inspection in October 2016 had been brought to the attention of staff and information shared with them about the process for rectifying the issues. However, we saw that where issues had been raised at nurse management meetings, they had not always been dealt with thoroughly.

For example, we saw that at the nurse management meeting held on 15 November 2016 the recording of medicine room and medicine fridge temperatures was raised. The minutes state 'nurses to ensure there is a room temperature chart in each treatment room and all charts to be completed on a daily basis' and 'fridge temperatures must be checked twice daily'. At this inspection we identified one treatment room where medicines were stored that had not had its temperature recorded. In addition, one medicines fridge had only had the temperature recorded on sixteen days during January. This meant the registered manager had failed to ensure that correct procedures had been followed.

During our inspection in October 2016 we identified that where people were having their food and fluid intake monitored and recorded, the records were not always completed accurately and that there were 'gaps' in the records. Accurate food and fluid records are necessary to allow staff to monitor that people have received sufficient food and fluids to maintain their health and well- being. We were told that auditing of food and fluid charts was now being undertaken to ensure they were completed correctly. However at this inspection we again found gaps in food and fluid charts. For example on Haven unit we found that at 13.30 on the day of our inspection four peoples' fluid charts did not have any fluids recorded for that day. On another person's food and fluid chart they were recorded as 'sleeping' during breakfast, at lunchtime nothing was recorded on the chart and at supper it had been recorded that they had 'small amounts of fluids, 50mls approximately'.

The issues identified above mean there was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

During this inspection we identified that the provider had failed to notify the Care Quality Commission (CQC) of a specific incident that had resulted in a person sustaining a serious injury. The registered provider has a

legal responsibility to inform the CQC of notifiable incidents.

Failure to notify the CQC of this incident was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider had recently employed a person into the role of 'care home support' and at the time of our inspection they had been in post for four weeks. Part of this role was to improve the auditing systems used by the home, including the introduction of a weekly environment audit, which was carried out by the lead nurses on each unit. Information from the weekly environment audit was then passed to the registered manager on the weekly handover form. The registered manager also planned to implement a regular 'spot check' of the environment on each unit. At the time of this inspection the new auditing system for the home was still being developed.