Care Quality Commission

Wood Green Nursing Home Limited

Wood Green 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 effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The provider is registered to accommodate and deliver nursing and personal care to a maximum of 40 older people. At the time of our inspection 20 people were living there.

We carried out an unannounced comprehensive inspection of this service on 8 May 2014 and 26 January 2015. A breach of legal requirements was found. The issues relating to the breach placed people at risk as the provider had failed to handle, store and administer prescribed medicines in such a way as to maintain and promote peoples good health. As a result of this continued non-compliance the provider was served with a warning notice for regulation 13 of the Health and Social Care Act 2008. The warning notice required the service to be compliant with the management of medicines by the 1 April 2015.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to Regulation 13 and the management of medicines.

You can read a summary of our findings from both inspections below.

Comprehensive Inspection of 26 January 2015

Summary of findings

The registered manager had left the service in August 2014. 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. The provider had appointed a new manager in November 2014 who told us that they were in the process of applying for registration with us.

We found that medicines management within the service were unsafe. The provider had failed to handle, store and administer prescribed medicines in such a way as to maintain and promote peoples good health. You can see what action we told the provider to take at the back of the full version of the report.

There were systems in place to protect people from abuse and harm. Staff had a clear knowledge of how to protect people and understood their responsibilities for reporting any incidents, accidents or issues of concern. However, the provider had failed to send notifications to the Commission and other external agencies about incidents or allegations of abuse that had occurred within the service.

The provider ensured that there were suitable number of staff on duty with the skills, experience and training in order to meet people's needs at all times.

Staff had access to a range of training to provide them with the level of skills and knowledge to deliver care safely and efficiently. Staff were encouraged by the provider to undertake training in addition to the standard level of training they were routinely provided with.

The provider supported the rights of people subject to a Deprivation of Liberties Safeguard (DoLS). Staff were able to give an account of what this meant when supporting the person and how they complied with the terms of the authorisation.

People's nutritional needs were monitored regularly and reassessed when changes in their needs arose. Staff supported people in line with their care plan and risk assessments in order to maintain adequate nutrition and hydration.

Staff were responsive to people when they needed assistance. Staff interacted with people in a positive manner and used encouraging language whilst maintaining their privacy and dignity. People were encouraged to remain as independent as possible.

People and their relatives told us they were provided with written and verbal information about the service and their care and treatment. People were supported to continue to maintain their religious observances.

Although people were provided with and information was on display about how to make a complaint. The provider had failed to respond in a timely manner and in line with their own policy to complaints received since our last inspection.

Activities that were on offer to people considered people's interests and hobbies through consultation with the individual. People, their relatives and stakeholders were asked to provide feedback about the service through questionnaires and meetings.

People, their relatives and staff spoke confidently about the leadership skills of the new manager. Structures for supervision allowing staff to understand their roles and responsibilities were in place.

The provider's quality assurance systems had failed to identify a lack of appropriate reporting and some analysis of incidents within the service and ineffective complaints handling that may have put people using the service at risk.

Focused Inspection of 14 April 2015

We undertook this focused unannounced inspection on 14 April 2015 to check that they had followed their plan and to confirm that they now met legal requirements. This inspection focused on the management of medicines from 1 April 2015. We found that sufficient improvements had been made.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (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.

Summary of findings

We found that medicines were being handled and administered in a safe manner, in line with the prescribing practitioner's instructions. Systems in place for the storage and safe disposal of medicines were effective.

This report only covers our findings in relation to our follow up of the breach and warning notice issued in relation to medicines management. You can read the report from our last comprehensive inspection by selecting the all reports link for Wood Green Nursing Home on our website at www.cqc.org.uk.

Summary of findings

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

26 January 2015

The service was not always safe.

People who used the service were being put at risk as medicines were not always administered, handled or stored in a safe manner.

Staff were knowledgeable and had received training about how to protect people from harm. People told us they felt safe using the service.

Risks for people in regard to their health and support needs were assessed and reviewed regularly.

The service operated safe recruitment practices and provided sufficient numbers of staff to meet people's needs.

14 April 2015

Where we had issued a warning notice, we found that action had been taken to improve the management of medicines. People were protected from any risks related to medicines. Medicines were administered, handled or stored in a safe manner.

We have revised the rating for safe from inadequate to requires improvement. This is because we need to ensure that the improvements made are continued, to ensure consistent good practice over time.

Is the service effective?

Good

The service was effective.

Staff received regular training and had the appropriate level of knowledge and skills to meet people's needs. Staff received regular supervision and used this as an opportunity to discuss their development and training needs.

People's ability to make important decisions was considered in line with the requirements of the Mental Capacity Act 2005.

People were supported to access specialist healthcare professional input from outside the service to meet their needs.

Is the service caring?

Good

The service was caring.

People and their relatives were complimentary about the staff and the care they received.

Summary of findings

Information about the service or their care was available for people using the service and their relatives.

We observed that people's privacy and dignity was respected by the staff supporting them.

Is the service responsive?

Requires improvement 

The service was not always responsive.

The provider had failed to respond to complaints received in a timely and effective manner.

People were actively involved in planning their own care. We saw that care was delivered in line with the person's expressed preferences and needs.

Activities offered within the service were planned in consultation with people using the service.

Visiting times were open and flexible enabling people to maintain links with family and friends.

Is the service well-led?

Requires improvement 

The service was not always well-led.

The provider had failed to inform the Commission and other external agencies of incidents that had occurred within the service.

People and their relatives spoke positively about the approachability of the manager.

Elements of the provider's quality assurance systems lacked a robust system for addressing identified gaps or omissions.

Wood Green Nursing Home

Detailed findings

Background to this inspection

This inspection report includes the findings of two inspections of Wood Green Nursing Home. We carried out both inspections 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 first was a comprehensive inspection of all aspects of the service that took place on 26 January 2015.

That inspection identified two breaches of the Regulations. The second inspection was undertaken on 14 April 2015 and focussed on checking action was taken in relation to the warning notices we issued following our inspection of 26 January 2015. You can find full information about our findings in the detailed key question sections of this report.

Comprehensive Inspection of 26 January 2015

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 of Wood Green Nursing Home took place on 26 January 2015 and was unannounced. The inspection team consisted of two inspectors, a pharmacist inspector and an Expert by Experience of older people's care services. An Expert of Experience is someone who has personal experience of using or caring for a user of this type of care service.

Before the inspection we reviewed the information we held about the service including notifications of incidents that the provider had sent us. Notifications are reports that the provider is required to send to us to inform us about incidents that have happened at the service, such as accidents or a serious injury.

During our inspection we spoke with eleven people who used the service, four relatives, one member of kitchen staff, five care staff, the deputy manager, the manager and the director of the service. We observed care and support provided in communal areas and with their permission spoke with people in their bedrooms. Prior to our inspection we also liaised with the local authority and Clinical Commissioning Group (CCG) to identify areas we may wish to focus upon in the planning of this inspection. The CCG is responsible for buying local health services and checking that services are delivering the best possible care to meet the needs of people. Following our inspection we contacted healthcare professionals who had regular contact with the service to obtain their views.

We reviewed a range of records about people's care and how the home was managed. This included looking closely at the care provided to three people by reviewing their care records, we reviewed two staff recruitment records, all the staff training records, all the medication records and a variety of quality assurance audits that the director and manager completed. We looked at policies and procedures which related to safety aspects of the home and also looked at whistle blowing and safeguarding policies.

Focused Inspection of 14 April 2015

We undertook a focused inspection of Wood Green Nursing Home on 14 April 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 26 January 2015 inspection had been

Detailed findings

made. We inspected the service against one of the five questions we ask about services: is the service safe. This is because the service was not meeting some legal requirements.

The inspection was undertaken by a pharmacy inspector.

In February 2015 we attended meetings arranged by the local authority with the provider and a range of other health and social care professionals involved with the service. This gave us an overview of where the service was in terms of improvements and changes that had been made.

We spoke with the deputy manager, three members of staff and two people using the service. We looked at what arrangements the service had in place for the obtaining, recording, storage, safe administration and disposal of medicines.

Requires improvement

Is the service safe?

Our findings

Findings from our comprehensive Inspection of 26 January 2015

At our last inspection in May 2014 we found that the service did not have a robust system in place to record where analgesic patches had been applied to on people and that instructions to administer some medicines prescribed with specific administration times, had not been adhered to. At this inspection people and relatives we spoke with told us they were satisfied with how their medicines were provided. One person told us, "I get my medication when I want it". Another person said, "I get mine on time, more or less". A relative stated, "My relative receives their medication on time, as far as I know". Although people expressed satisfaction with medication management we found some issues which meant that medication management was not safe and put people at risk of not receiving their prescribed medication as they should.

We reviewed how medicines were managed within the service. At our last inspection in May 2014 we found that the provider was not compliant with the regulations in regard to medicines management. We asked the provider to outline how they intended to improve and meet the regulations in an action plan. We received this action plan in July 2014 and as part of this inspection checked that the improvements outlined in the action plan had occurred and had been maintained. We found the service had failed to sustain improvements in regard to safe medicines management.

Nine Medication Administration Records (MAR) were looked at in detail and we found that people's medication was not being administered as prescribed. For example we found that staff had not signed the MAR; we found discrepancies in the levels of medicines left in stock so we were unable to establish if the medicines had been administered. We found records did not evidence that people had received their inhaled medicines as prescribed. One person who required a medicine to be administered at specific times was not receiving the medicine at the times specified. We noted that the service had identified that the wrong dose of one medication had been administered for six days following a poor blood test result. This resulted in the person needing a high level of monitoring for several days until their health condition had stabilised with the correct dosage of medication. People requiring medicines to be administered directly into their stomach via a tube, were not receiving their medication in line with the necessary guidance to ensure that they were administered safely. We observed unsafe administration practices during the lunchtime medicines round, for example, we saw that administration records were being signed before the medicines had been given.

We found that daily fridge temperatures checks were not being recorded consistently. When the refrigerator temperature had been recorded we saw that it had been above the maximum temperature for a number of days, but we were advised that no action had been taken to address the problem. This meant that medicines were not being stored as per the manufacturer's guidelines to maintain their effectiveness in promoting good health.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Relatives told us they were happy with the support available and that the environment was safe for their family member to reside in. One person told us, "Yes I feel safe, I've been here years I should know". Another said, "If I have to use my buzzer when I'm in my room, it never takes them long to come to me". One relative told us "Yes it's safe, I'm happy with the place".

Staff were clear about their responsibilities for reporting any concerns. One staff member said, "If I identify any issues or concerns I can discuss them straight away with the managers". Staff told us they felt the training they had received had equipped them with the necessary knowledge and information they needed in order to protect and keep people safe.

Records showed that assessments had been completed in respect of any risks to people's health and support needs. These referred to the individual's abilities and areas that they needed assistance with in order to avoid harm and reduce any related risks. For example, through our observations we were able to see how staff used moving and handling equipment in such a way as to protect people from harm and in line with their individual needs outlined in their care plans.

Records demonstrated that the provider had undertaken the appropriate pre-employment checks, which included references from previous employers and criminal records checks. Disciplinary procedures within the service were

Requires improvement

Is the service safe?

reviewed. Records showed that the provider had taken appropriate action by internally investigating allegations and dealing with staff involved in line with their policy, when incidents had arose.

We saw that there were sufficient numbers of staff on duty to meet people's needs. We observed people being responded to in a timely manner, including answering of call bells. One person said, "If I'm in bed, staff make sure I have my buzzer; if I buzz they come fairly quickly". A second person told us, "There are a lot of people in here, but I get looked after okay, so I think I'm satisfied enough". We saw that staff were apparent and available to assist people in communal areas. The manager told us that staffing levels were determined in line with peoples changing needs using a staffing guidelines tool. People and their relatives told us they had no concerns over staffing levels.

Findings from 14 April 2015 Focused Inspection

We found that the provider had taken action to meet the requirements of Regulation 13 of the Health and Social Care Act 2008.

We looked in detail at 8 medicine administration records (MAR) and found that people's medical conditions were being treated appropriately by the use of their medicines. We found that the MAR demonstrated that people were getting their medicines at the frequency that their doctor had prescribed them. People we spoke with told us they got their medicines when they needed them and were happy with how staff looked after their medicines.

We reviewed the records for people who were having medicinal skin patches applied to their bodies; we found that records of where the patches were being applied were in order and evidenced that they were being applied safely.

We saw that people who had been prescribed medicines on an 'as required' basis were provided with these medicines in a consistent way. Records we reviewed contained sufficient guidance about how and when to administer these medicines, to ensure that the medicines were given in a timely and consistent way.

Medicines were found to be stored securely and at the correct temperature, for the protection of the people who lived there. Those medicines requiring cool storage were being stored at the correct temperature and so would maintain their effectiveness. We looked at the disposal records for medicines that were no longer required by the service and found they had improved. The records showed that unwanted medicines were being disposed of safely.

We observed a lunchtime medicines administration round and saw that good administration practices were in place. We saw that administration records were referred to prior to the preparation and administration of the medicines and the MAR was being signed after the medicines had been given.

We have revised the rating for safe from inadequate to requires improvement. This is because we need to ensure that the improvements made are continued to ensure consistent good practice over time. We will check this during our next planned comprehensive inspection.

Good

Is the service effective?

Our findings

(Text unchanged from comprehensive inspection)

Good

Is the service caring?

Our findings

(Text unchanged from comprehensive inspection)

Requires improvement

Is the service responsive?

Our findings

(Text unchanged from comprehensive inspection)

Requires improvement

Is the service well-led?

Our findings

(Text unchanged from comprehensive inspection)

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **26 January 2015** The provider had failed to report to the Commission incidents that had resulted in, or had the potential to result in harm to a person using the service. **14 April 2015** This breach of the regulation was not reviewed at this focussed inspection.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **26 January 2015** The provider had failed to protect people using the service against the risks associated with the unsafe use and management of medicines. **14 April 2015** The provider is now meeting this regulation.

The enforcement action we took:
We issued a warning notice following our inspection on 26 January 2015.