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Northwood Nursing & Residential Care

Inspection report

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Ratings

Is the service safe?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 23 March 2015 at which a breach of legal requirements was found. This was because the systems to ensure the safe administration of medicines in Northwood were not sufficiently robust to ensure people who used the service were adequately protected.

After the comprehensive inspection the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook an unannounced focused inspection on 4 September 2015 to check that they had followed their plan and to review whether they met the legal requirements in relation to the management of medicines. We found that the required improvements had not been made. This meant there was a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of this report.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Northwood Nursing & Residential Care' on our website at www.cqc.org.uk.

Northwood is registered to provide accommodation for up to 27 older people who require support with nursing or personal care needs. At the time of our inspection there were 24 people using the service.

The service had a registered manager in place. 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 and associated Regulations about how the service is run. The registered manager was supported in the day to day running of the service by a care manager.

The provider had made some improvements to the management of medicines in the service. This included

Summary of findings

introducing a system to assess the competence of staff to safely administer medicines and regular audits to check that medicines had been administered as prescribed. However we found the audit process had not been sufficiently robust to identify the issues we noted during the inspection.

We found the medicine administration records (MAR) charts were not always accurate or fully completed. This meant we could not be certain people who used the service had always received their medicines as prescribed.

Care plans and risk assessments were not in place to provide information for staff about the action to take where it had been agreed that medicines could be administered in food or drink. Protocols were also not in place to ensure staff understood when to give medicines prescribed on an 'as required' basis. This meant there was a risk people might not receive all the medicines they needed.

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?

The service was not safe. This was because not all the required improvements had been made to ensure people were protected from the risks associated with the unsafe management of medicines.

Requires improvement

Northwood Nursing & Residential Care

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 Northwood on 4 September 2015. The inspection was undertaken to check whether improvements to meet legal requirements planned by the provider after our comprehensive inspection on 23 March 2015 had been made. We inspected the service against one of the five questions we ask about services: is the service safe? This was because the service was not meeting legal requirements in relation to that question.

The inspection was undertaken by two adult social care inspectors.

Before our inspection we reviewed the information we held about the service; this included the provider's action plan which set out the action they would take to meet legal requirements in relation to the management of medicines.

During the inspection we looked at the (MAR) charts for all the people who used the service. We spoke with the registered manager, the care manager and the nurse responsible for the administration of medicines on the day of the inspection.

We spoke with two people who used the service to check if they received their medicines as prescribed. We also looked at records in relation to the administration of medicines in the service.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Northwood on 23 March 2015 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 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 4 September 2015 we found the required improvements had not been made. This meant there was a breach of regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with two people who used the service regarding the support they received from staff in relation to their medicines. Both people told us they always received their medicines as prescribed. One person commented, "I always get my medicines in the morning. I know roughly what I am taking. Staff are very good." They also told us that staff had ensured they received the correct medicines following their discharge from hospital when their prescription had been amended.

We reviewed the MAR charts for all the people who used the service. We found 14 of the records we reviewed were incomplete. Medicines had not always been signed for on 10 of these records. One person's MAR chart had not been signed since 10 August 2015 to confirm one medicine had been given. However when we checked the monitored dosage system used in the service we noted this medicine was included in the single dose pot given each morning to the person concerned. The nurse on duty on the day of the inspection could not give any explanation as to why the MAR chart had not been fully completed.

There were incomplete administration details for some medicines on three of the MAR charts we reviewed. One person's record contained information about a medicine which the nurse on duty told us had not been administered as it had been discontinued. The MAR chart did not indicate that this medicine was no longer prescribed. The lack of accurate records meant there was a risk people would not receive their medicines as prescribed.

At our last inspection in March 2015 we were concerned about the lack of care plans or risk assessments where it had been agreed that medicines could be given in food or drink in a person's best interests. On this inspection we looked at the care records for two people where the MAR charts stated that their medicines could be given in food or drink. We noted there was no care plan in place to provide information for staff regarding the circumstances in which the medicines should be mixed with food or drink. There was also no risk assessment in place to advise staff what action to take should a person fail to consume all the food or drink in which the medicine had been administered. This meant there was a risk people would not receive all of their prescribed medicines.

We looked at the charts which recorded when the creams prescribed to people who used the service had been administered. These charts were kept in people's bedrooms and were completed by care staff. At our last inspection in March 2015 we were concerned that these charts were not always being completed by staff. On this inspection we found some improvement to the records where people who used the service were prescribed cream to be administered once a day. However, we found eight charts had not been fully completed where people were prescribed creams to be administered twice daily. We discussed this with both the registered manager and care manager who could not give any explanation for the lack of accurate records relating to the administration of creams.

When we inspected the service in March 2015 we found there were no systems in place to document when people should receive any medicines which were prescribed on an 'as required basis'. On this inspection we found there were still no protocols in place to advise staff of the reasons why a person might need an 'as required' medicine and the symptoms a person might display to indicate they needed the medicine where they were unable to ask staff directly. The registered manager told us this was because only trained nurses administered medicines and they considered these staff should be able to use their own judgment to decide when any 'as required' medicines should be administered. However, the lack of documentation to support this meant there was a risk people would not always receive the medicines they needed.

Since our last inspection in March 2015 we noted the registered manager had introduced a system of regular

Requires improvement

Is the service safe?

medication audits. However, we were told cream charts were not currently included in this audit. When we looked at the most recent audit completed on 20 August 2015 we noted that this included a review of the medicines for the person whose MAR chart had not been signed to record the administration of one medicine since 10 August 2015. However, the completed audit tool confirmed that all MAR charts had been correctly completed. The registered manager could not give any explanation for this discrepancy. This meant the audit process was not sufficiently robust to identify where errors had occurred in the administration of medicines.

Since our last inspection the registered manager had also introduced a system to check whether staff were competent to administer medicines safely. However, as a result of our findings from the inspection the registered manager told us they would be reviewing this with all the nursing staff.

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
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with the unsafe management of medicines.

The enforcement action we took:
We issued a warning notice.