Swinton Hall Nursing Home Limited

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Inspection report

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28 April 2016

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20 June 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service responsive?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 06 January 2016. During that inspection we two breaches of Regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to administration of medication and person centred care. After that inspection, the provider wrote to us to tell us what action they had taken to meet legal requirements in relation to these breaches of regulation.

Swinton Hall Nursing Home is a privately owned nursing home close to the A580, East Lancashire Road and is within easy access to the cities of Salford and Manchester. The home is registered to provide accommodation with personal and nursing care for up to 62 people across three units. The home comprises of a 15 bed continuing care unit to support people with complex nursing needs and a nursing unit.

There was no registered manager in place at the time of our inspection, however a manager had been appointed and was in the process of applying to register with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

As part of this focused inspection we checked to see that improvements had been implemented by the service in order to meet legal requirements. 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 Swinton Hall Nursing Home on our website at www.cqc.org.uk.

At the last inspection visit on 06 January 2016, we found that medicines were not handled safely. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, because the service had not protected people against the risks associated with the safe management of medication. We told the provider they must take action to improve the safe handling of medicines.

We found records still could not be relied on to demonstrate that people had received their medication safely and in line with their prescription.

We also looked at the records relating to the application of prescribed creams. We found the information recorded to guide staff as to which creams to apply were incomplete. We found that the information did not include all their prescribed creams. The records showed creams were not applied as prescribed.

We saw that the records about the quantities of mediation held in the home for each person were inaccurate. We found more medication was in stock that had been recorded as being available. This meant audits and checks could not be done to show that medicines had been given as prescribed.

We found one person was not given their prescribed medication for almost four days, because there was

none available. Another person's tube of gel to replace their saliva had been almost all used up, but none had been ordered to maintain a continuity of supply. If medicines are unavailable people's health maybe placed at risk.

We found that medicines were not administered safely. We saw one person did not have one of their heart medicines for 18 days, even though it was in stock and available for administration. We also found when we compared the stock of tablets with the records of administration, that it had not been administered as many times as it had been signed for. The same person was prescribed some tablets to be taken each night. However, despite the fact they had been signed as given on ten out of 17 nights, the box was sealed and none had been given.

Medicines were not administered in accordance with the manufacturers' directions regarding food. We saw that medicines, which must be given before meals were given at the same time as medicines which need to be given with food. If medicines are given at the wrong times with regard to food they may not work properly and people will not receive the full benefit of their medication, which places their health at risk.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, because the service had not protected people against the risks associated with the safe management of medication. CQC are currently considering there enforcement action in respect of these concerns.

Prior to this visit we received information of concern regarding staffing levels relating to qualified nurses and an over reliance of agency nurses. We looked at how the service ensured there were sufficient numbers of staff on duty to meet people's needs and keep them safe. We looked at rotas and spoke to staff on duty about whether they had any concerns about staffing levels. We found there were sufficient numbers of staff on duty during the day and night to support people who used the service.

During our last inspection we found that the provider failed to provide care and treatment that met individual needs and reflected personal preferences. This related to providing opportunities for people to take part in activities they enjoyed, which met their personal preferences. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care

During this inspection we found that the service was able to demonstrate that they were now meeting the requirements of regulations. We found that the service had installed a sensory therapy suite. This provided opportunities for people living with different stages of dementia to be stimulated and engage in activities, either as a group or individually with the activities coordinator. People engaged in recreational pass times such as card making and craft work. We saw people making use of this facility during our visit.

The activities coordinator told us they were fully supported by the management team, who ensued the role was a dedicated position. We found that were people chose not to involve themselves in group events, they had the option of one to one stimulation with the activity coordinator. Records were maintained of what activities and engagement people participated in.

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

We found that action had not taken to ensure people were protected from the risks associated with the safe management of medication.

We saw that the records about the quantities of mediation held in the home for each person were inaccurate. We found more medication was in stock that had been recorded as being available.

We found that medicines were not administered safely. We saw one person did not have one of their heart medicines for 18 days, even though it was in stock and available for administration.

As the last comprehensive inspection took place less than six months ago, we have reviewed the overall rating of this domain, which now reflects the service's continuing failure to ensure the administration of medications are safe.

Is the service responsive?

Requires Improvement

We found the provider was now meeting the requirements of the regulation In relation to providing care and treatment that met individual needs and reflected personal preferences.

We found that the service had installed a sensory therapy suite. This provided opportunities for people living with different stages of dementia to be stimulated and engage in activities, either as a group or individually with the activities coordinator. People engaged in recreational pass times such as card making and craft work.

We could not improve the rating for 'responsive' from requires improvement at this time, because to do so required evidence of consistent good practice over time. We also only looked at aspects relating to the breach of regulations, rather than looking at the whole question relating to 'responsive.' We will review this during our next planned comprehensive inspection.

Swinton Hall Nursing Home Limited

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 at Swinton Hall Nursing Home on the 28 April 2016. This inspection was undertaken to ensure that improvements that were required to meet legal requirements had been implemented by the service following our last inspection on 06 January 2016.

We inspected the service against two of the five questions we ask about services during an inspection, which were not meeting legal requirements. These included; 'Is the service Safe' and 'Is the service Responsive.'

The inspection was undertaken by one adult social care inspector and a CQC pharmacist. Before the inspection, we reviewed all the information we held about the home, including concerns that we had received. We reviewed statutory notifications and safeguarding referrals. We also received information of concern regarding staffing levels.

We also reviewed the action taken by the provider following our previous inspection, who wrote to us explaining what action the service had taken to meet legal requirements.

As part of the inspection, we spoke to the new manager, the Operations Director, Operations Manager, three nurses, two agency nurses, five members of care staff, including the activities coordinator and a visiting relative to the home.

Inadequate

Is the service safe?

Our findings

At the last inspection visit on 06 January 2016, we found that medicines were not handled safely. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, because the service had not protected people against the risks associated with the safe management of medication. We told the provider they must take action to improve the safe handling of medicines.

During our inspection visit on 28 April 2016, we looked at medication and records about medication for two people in depth and for three other people in less detail. We found serious concerns and saw that medicines were not handled safely. Safeguarding referrals were made by the manager as a result of our findings.

At our last inspection we found that records supporting and evidencing the safe administration of medicines were not always complete and accurate. During this visit, we found a number of signature omissions in these records. This meant the records still could not be relied on to demonstrate that people had received their medication safely and in line with their prescription.

We also looked at the records relating to the application of prescribed creams. We found the information recorded to guide staff as to which creams to apply were incomplete. We found that the information did not include all their prescribed creams. The records showed creams were not applied as prescribed. For example, one person was to have a cream applied twice daily to their legs. The records showed this cream was only applied once every two weeks. They were prescribed another cream to be used when washing and the records showed it had only been used once in 10 days. We had similar concerns at the last inspection where it was noted the previous manager had taken immediate steps to address these deficiencies. However, the actions had not been sustained and people were not having their creams applied as prescribed.

At the last inspection, we found that fridge temperatures had not been recorded regularly. At this inspection we saw the temperatures were now recorded daily, however the temperatures recorded for one fridge showed that the maximum recorded temperature each day was 19.5C and the minimum was -0.1C. Fridge temperatures should be between 2C and 8C for the safe storage of medicines. The nurse on duty told us she did not know what the safe operating temperature of the fridge should be. Nurses had failed to report that medicines may have been stored at incorrect temperatures and medicines may not have been safe to use as a result.

We saw that the records about the quantities of mediation held in the home for each person were inaccurate. We found more medication was in stock that had been recorded as being available. This meant that audits and checks could not be done to show that medicines had been given as prescribed.

We found one person was not given their prescribed medication for almost four days, because there was none available. Another person's tube of gel to replace their saliva had been almost all used up, but none had been ordered to maintain a continuity of supply. If medicines are unavailable people's health maybe

placed at risk.

We found that medicines were not administered safely. We saw one person did not have one of their heart medicines for 18 days, even though it was in stock and available for administration. We also found when we compared the stock of tablets with the records of administration, that it had not been administered as many times as it had been signed for. The same person was prescribed some tablets to be taken each night. However, despite the fact they had been signed as given on ten out of 17 nights, the box was sealed and none had been given.

We saw that when medication was discontinued it was not disposed of or segregated form the medication that was currently prescribed. This placed people at risk of being given medication that was no longer prescribed.

We saw that three people whose records we looked at were prescribed medicines to be given 'when required.' We saw that there was no information to guide staff when administering medicines, which were prescribed in this way. The manager confirmed there were no 'PRN protocols' in place. We looked at a blank protocol that should have been in place. It is important that clear guidance is recorded about when and how to give medicines prescribed in this way, especially for agency staff who do not know the residents well. If this information is missing, especially for people with dementia, medicines may not be given effectively or consistently and people's health would be placed at risk.

People who are prescribed insulin must have their blood sugars monitored. We found one person was having their levels monitored, but there was no information to tell nurses what the safe range should be. For another person we saw there was very clear guidance about what to do if their blood sugar levels fell outside their safe range. However, we saw that the nurses failed to take any action when the levels were unsafe.

Medicines were not administered in accordance with the manufacturers' directions regarding food. We saw that medicines, which must be given before meals were given at the same time as medicines which need to be given with food. If medicines are given at the wrong times with regard to food they may not work properly and people will not receive the full benefit of their medication, which places their health at risk.

We saw that medicines were not transported round the home safely. The manager told us that the trolley was not big enough to hold the medicines. Nurses had to prepare people's medicines in the medication room and then placed them in a small basket and go and find the resident to take the tablets. We noticed the nurse on duty did not take the records with them. This is not safe practice as it could lead to errors or misadministration. We saw that people's creams were kept in their bedrooms without a risk assessment to show it was safe to keep medicines there. Waste medication was not segregated from current medication and was not kept in line with the NICE guidance.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, because the service had not protected people against the risks associated with the safe management of medication. CQC are currently considering their enforcement action options in respect of these continuing concerns.

During the inspection, we found some people were given all their food, drinks and medication via a PEG tube, which is tube inserted in their stomach. We found there was no clear information with the medication administration charts to indicate they were unable to have their medication orally. We also found that the information in the care plans had not been updated to reflect the current feeding regimes or their changing ability to take anything orally. The nurse told us that these people were 'unable to speak,' therefore they

could not tell agency nurses they were not able to eat or drink. We saw that the PEG tube was not flushed in accordance with the dietician directions. We spoke to the manager about these matters, who assured us these issues would be addressed immediately.

Prior to this visit we received information of concern regarding staffing levels relating to qualified nurses and an over reliance of agency nurses. We looked at how the service ensured there were sufficient numbers of staff on duty to meet people's needs and keep them safe. We looked at rotas and spoke to staff on duty about whether they had any concerns about staffing levels. We found there were sufficient numbers of staff on duty during the day and night to support people who used the service.

On the day of our visit, we found one nurse worked on the Continuing Care Unit and had responsibility for 12 people who used the service. They were supported by two members of care staff. On the nursing unit, there were two nurses responsible for 40 people who used the service and were supported by nine care assistances. The manager told us they used agency nurses to cover any shortfalls and were currently endeavouring to recruit permanent nurses as they currently had five vacancies. They explained that recruiting nurses was very difficult and they had tried to recruit nurses from abroad. They also explained that when reliant on agency nursing staff, they tried to use the same agency nurses to ensure continuity for people who used the service.

One visiting relative told us, "I have never felt my relative was not safe in respect of staffing, staffing levels can be tight at times." One member of nursing staff told us, "Staffing levels are always very good and that includes care staff levels." Another nurse said "With staffing, people are safe as far as I'm concerned. We are all pulling together as a team. The new manager has changed things and we are better as a team as a result." Other comments from nursing staff included, "No concerns about staffing levels here, it's never an issue." "Staffing levels are currently good, no concerns. They are really trying to get continuity with nursing staff."

Requires Improvement

Is the service responsive?

Our findings

During our last inspection we found that the provider failed to provide care and treatment that met individual needs and reflected personal preferences. This related to providing opportunities for people to take part in activities they enjoyed, which met their personal preferences. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care

During this inspection we found that the service was able to demonstrate that they were now meeting the requirements of regulations. We found that the service had installed a sensory therapy suite. This provided opportunities for people living with different stages of dementia to be stimulated and engage in activities, either as a group or individually with the activities coordinator. People engaged in recreational pass times such as card making and craft work. We saw people making use of this facility during our visit.

We saw that in each unit an activities board provided a list of monthly activities. These included healthy hearts and hips, film matinées, fundraising events, such as making cards and bird boxes, singers, acting groups and garden parties. The activities coordinator told us that trips were also arranged to take people to Blackpool or the Trafford Centre. The home held 'mass and communion' every fortnight with a local priest to meet people's spiritual needs.

The activities coordinator told us they were fully supported by the management team, who ensued the role was a dedicated position. We found that were people chose not to involve themselves in group events, they had the option of one to one stimulation with the activity coordinator. Records were maintained of what activities and engagement people participated in.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations 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
Treatment of disease, disorder or injury	The service had not protected people against the risks associated with the safe management of medication.

The enforcement action we took:

CQC have issued a warning notice with conditions to be met by 27 June 2016.