Mr Bharat Kumar Modhvadia and Mrs Jaya Bharat Modhvadia

Abbeydale Nursing Home

Inspection report

Croyland Street
Kirkdale
Liverpool
Merseyside
L4 3QS

Tel: 01512982218

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 19 April 2016, at which continual breaches of legal requirements were found. These breaches were in relation to medicines not being managed safely, care records lacking detail and audits or checks not identifying issues we found. We also made a recommendation about how the service was seeking consent from people who lived at the home.

Following the comprehensive inspection, the provider wrote to us to say what they would do to meet the breaches. We undertook this focused inspection to check that the provider was now meeting the legal requirements. This report only covers our findings in relation to these breaches and the recommendation. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Abbeydale Nursing Home' on our website at www.cqc.org.uk.

Abbeydale Nursing Home provides nursing and personal care for up to 36 people, many of whom are living with dementia. The home is situated in Kirkdale, north of Liverpool city centre and is located near to public transport links and other community facilities.

There were 25 people living in the home at the time of our inspection.

A registered manager was in post. A registered manager is a person who has registered with the 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.

Although some improvements had been made to medicines management since the last inspection we found that the management of medicines was still not safe. Nurses were not always giving prescribed medicines at the correct time with regard to food. For example, a person was given their prescribed antibiotic with their meals which was not in accordance with the manufacture's guidance that stated it must be given before food. Arrangements were not in place to order prescribed medication in a timely manner.

Records were not always made at the time medicines were given; this is not good practice because it relies upon people remembering to accurately fill in the records at a later time, which leads to inaccuracies. There was either no information or insufficient information to guide staff when administering medicines that were prescribed to be given 'when required' or as a 'variable dose'.

There was no recorded information for nurses to refer to regarding people's safe range for their blood sugars to ensure they were given their insulin safely. There were no care plans in place regarding what to do in the event of a diabetic emergency.

Audits or checks to monitor the quality of care provided were in place but were not effective as they had not

picked up on issues we identified with medicines and care records.

There was no information recorded to indicate how people who used bedrails had consented to use of this equipment. Bedrails can be considered a form of restrictive practice so if a person is unable to consent to their use then ensuring they are used in a person's best interest is important. We did not see that mental capacity assessments and best interest discussions had been completed for the use of bedrails.

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

The service was not always safe.

Although some improvements had been made to medicines management since the last inspection we found that medicines were still not being managed in a safe way. People were not always receiving their medicines as prescribed by the doctor.

Is the service effective?

Requires Improvement

The service was not always effective.

It was not clear how people's consent had been obtained in relation to the use of bedrails. This is important as bedrails can be considered a form of restrictive practice. There was no record of a mental capacity assessment or best interest discussion having taken place for people who the ability to provide informed consent.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Some improvements had been made regarding the management of care records. Although care plans were now being regularly reviewed, some lacked enough detail to be fully informative.

The medicines and care plan audits were not fully effective as they did not identify some of the issues we found.

Abbeydale Nursing 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 inspection took place on 8 August 2016. The inspection team included an adult social care inspector and a pharmacist inspector.

Before our inspection we reviewed the information we held about the home, including the notifications the Care Quality Commission (CQC) had received about the service. As part of the inspection we sought the views of two health or social care professionals who visited the home to monitor the improvements that were being made.

During the inspection we spoke with the registered manager, a registered nurse, one of the care staff and two of the people living at the home.

We looked at the care files for four people living at the home, four staff personnel files, medicine administration charts for 17 people and other records relevant to the quality monitoring of the service. We looked around the home, including some bedrooms, bathrooms, the dining rooms and lounges.

Requires Improvement

Is the service safe?

Our findings

When we carried out the comprehensive inspection of Abbeydale Nursing Home in April 2016 we identified a breach of regulation in relation to the safe management of medicines. At the previous inspections in May 2015 and November 2015 we also found that medicines were not handled safely.

At this inspection we found that limited improvements had been made in the safe management of medicines. The improvements that had been made were insufficient to fully protect people from the risks associated with the unsafe handling of medicines. During the inspection we looked at medication and records about medication for 17 of the 25 people living in the home and found concerns about medicines handling for all 17 people.

On the day of the inspection visit the morning medicines round was not competed until 11:30 am and the lunch time medication round was started at just after 2:00 pm. Nurses did not record the time they gave people medicines which meant that people could be given their medication with an unsafe time interval between doses.

We saw that nurses were still failing to give prescribed medicines at the correct time with regard to food. We saw that one person was given their newly prescribed antibiotic with their meals ignoring the manufacture's guidance which stated it must be given before food. Once again we found that the records showed that the person, who had been prescribed an antispasmodic tablet to be taken 20 minutes before food to help relieve the stomach spasms, was not given it at the correct time. We found that another person was given one medication which should be given before meals together with a tablet that should be given with meals. If medicines are not given correctly with regard to food they may not work properly which places people's health at risk of harm.

We saw that nurses still failed to accurately follow the prescribers' directions when administering medication. One person was prescribed an inhaler; two puffs to be given in each dose. The records showed that nurses had only given half the prescribed dose for over a week. Nurses failed to notice the on-going medication error.

Nurses still failed to make arrangements to order prescribed medication in a timely manner. We saw that one person ran out of their regularly prescribed Paracetamol for almost two days. We also found that care staff recorded that several creams ran out for periods of almost a month. If medicines are unavailable people's health maybe placed at risk.

We found that improvements had been made to some aspects of records keeping about medicines and saw that they now demonstrated that medication in the home could be accounted for. However, when we did a stock check of Paracetamol for one person we found that two tablets had been signed but not administered. We saw that clear records were made when doses were changed or medicines were discontinued. However, we found at this inspection that records were not always made at the time medicines were given; this is poor practice because it relies upon people remembering to accurately fill in

the records at a later time which leads to inaccuracies and the possibility a double dose of medication could be given.

As at previous inspections we found that the quality of records, about the application of creams and the use of thickening agents (added to fluids help people with swallowing difficulties drink fluid without choking) were poor and did not give evidence that they had been used.

At this inspection we saw there was sufficient information recorded about how and where to apply topical medicines (creams) to ensure that the care staff could apply them safely. However, the records showed this information was not always followed. We also saw that creams which were no longer listed as being currently prescribed were being applied by care staff. Therefore nurses failed to ensure that the carers were applying creams properly.

We saw that there was still either no information or insufficient information to guide staff when administering medicines that were prescribed to be given 'when required' or as a 'variable dose'. If this information is missing, particularly for people living with dementia, medicines may not be given effectively or consistently, and people's health could be at risk.

We also found that there was still no recorded information for nurses to refer to regarding people's safe range for their blood sugars to ensure they were given their insulin safely. No were there clear instructions recorded to guide staff in the event of a diabetic emergency.

This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

When we carried out the comprehensive inspection of Abbeydale Nursing Home in April 2016 we made a recommendation in relation to seeking consent to care from people living at the home. This was mainly in relation to advanced care plans (ACP) that had been developed by nurses once a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) had been put in place by the GP. The ACPs were not being undertaken in accordance with best practice guidance. In addition, mental capacity assessments were being used for routine non-complex decision making, which is not in keeping with the principles of the 2005 Mental Capacity Act (MCA).

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We looked at four care records. DoLS authorisation plans were stored in the care records. We did not see a care plan summarising and outlining what the DoLS meant in practice for each person. This would be useful information for all staff. The ACPs that we looked at were in various stages of completion but had not progressed enough to show involvement of the person's family.

The care documentation format had been changed since the last inspection. However, we noted that the mental capacity assessments continued to be completed for routine non-complex decision making, such as consenting to personal care. This was not in keeping with the principles of the MCA and improvements had not been made since the last inspection.

Two of the care records we looked at showed that the people used bedrails. There was no information recorded to indicate how each of the people had consented to use of this equipment. Bedrails can be considered a form of restrictive practice so if a person is unable to consent to their use then ensuring they are used in a person's best interest is important. We did not see that mental capacity assessments and best interest discussions had been completed for the use of bedrails.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

When we carried out the comprehensive inspection of Abbeydale Nursing Home in April 2016 we identified a breach of regulation in relation to governance of the service. At the previous inspections in May 2015 and November 2015 we also found that governance processes were not robust. This was because clinical care plans did not always reflect people's current needs. In addition, audits, including checks of medicines and care record audits were not identifying issues we found.

At the previous inspection we found that care plans had not been put in place in relation to tissue viability. There was no information about the person's wound, the type of dressing required and the frequency of the dressing changes. There was nobody living at the home at this inspection that required dressings.

We noted from the training records that all the nurses had received training in wound care, and had also received training in medicines management, diabetes and care planning. Personnel records informed us that the nurses had been subject to competency checks regarding the administration of medicines. In addition, nurses had received regular supervision that included discussions regarding their clinical practice.

At this inspection we found that some improvements had been made to the care records. For example, care plans were being reviewed by nurses on a regular basis. However, some care plans continued to lack detail so therefore were incomplete. These included care plans for diabetes and the action to take in the event of a diabetic emergency. Furthermore, we found that risk assessments for the use of bedrails also lacked sufficient detail. It is important to clearly record how the risks were assessed because, if not used appropriately and in a safe way, bedrails can cause a risk to the person's safety. Medication and care plan audits had not picked up on some of the issues we found, such as the concerns with topical medicines and the use of 'when required' medicines.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager took prompt action following the inspection. This included meeting with the nurses as the main concerns identified were in relation to clinical practice. Performance of the nursing staff had been reviewed and action taken accordingly. The registered manager advised us that an experienced registered nurse had been recruited to take on the role of clinical lead for the service.