Vorg Limited

Southwoods 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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 23 November 2015. A breach of legal requirements was found relating to the safe administration of medicines. 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 this unannounced focused inspection on 17 October 2016, to check that they had followed their plan and to confirm that they now met 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 Southwoods Nursing Home on our website at www.cqc.org.uk

Southwoods Nursing Home is registered to provide personal and nursing care for up to 38 older people. At the time of our inspection the service was providing care to 33 people.

The service had a registered manager. 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.

At this inspection we found that improvements had been made to the way staff administered medicines and this was now done safely. Competency checks took place to ensure staff administered medicines safely and there had been no serious medicine errors since our last inspection. Medicines were stored safely and records relating to oral medicines and controlled drugs indicated that these had been administered in accordance with prescribing instructions.

Improvements were needed to ensure that clear written information was available to support the safe use of topical medicines [medicines applied externally], medicines used only when required and medicines used covertly [without the person knowing]. The recording of the administration of topical medicines and transdermal patches also needed to improve, to ensure that these medicines were being administered correctly and as prescribed.

The medicine policy and procedure had been updated recently by the registered manager, but did not adequately reflect current best practice guidance, such as the NICE (National institute for Health and Care Excellence) guidelines on managing medicines in care homes.

These findings evidenced a repeated breach of Regulation 12 Heath and Social Care Act (Regulated Activities) Regulations 2014, and we have required that the provider and registered manager make further improvements to the management of medicines.

This inspection raised questions about how the provider and registered manager monitored the safety and

quality of the service, to effectively identify and make improvements when needed.

Arrangements were in place to review and update policies and procedures annually, but did not currently ensure that up to date best practice guidance was always incorporated appropriately.

The registered manager and other staff completed audits and monitoring activities. However, audits had not always been effective at identifying areas for improvement and had not resulted in action plans to ensure that issues identified were addressed effectively.

The provider carried out visits and talked regularly with staff to monitor the service and people's satisfaction levels. There was currently no other formal scrutiny or external support provided to the service, although this had been tried in the past with limited success.

These findings evidenced a breach of Regulation 17 Heath and Social Care Act (Regulated Activities) Regulations 2014, and we have required that the provider and manager make improvements to ensure that good governance systems are in place.

We will undertake a further comprehensive rating inspection in the near future to monitor what action the provider has taken to make improvements.

You can see what action we told the provider to take at the back of the full version of the report.

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 required improvement to be safe.

Medicines were stored safely. Oral medicines and controlled drugs were administered safely and in accordance with prescribing instructions.

Improvements were needed to ensure that clear administration instructions were available for topical medicines, medicines prescribed 'when required' and medicines administered covertly. Administration records for topical medicines were not clear or up to date.

Medicine policies and procedures did not adequately reflect up to date guidelines.

Is the service well-led?

Requires Improvement

The service required improvement to be well led.

A registered manager was in place and action had been taken to improve the specific concerns relating to medicine administration we identified during our last inspection.

Policies and procedures were reviewed annually, but this process did not always ensure that current best practice guidelines were incorporated.

A system of audits and checks was in place, but these had not always been effective in identifying problems or ensuring improvements were made.

Southwoods Nursing Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Southwoods Nursing Home on 17 October 2016.

This inspection was done to check that improvements planned by the provider to meet legal requirements after our 23 November 2015 inspection had been made. The team inspected the service against two of the five questions we ask about services: Is the service safe? Is the service well led? This was because the service was not meeting some legal requirements at our previous inspection.

The inspection was undertaken by a pharmacist inspector and an adult social care inspector.

Before our inspection we reviewed the information we held about the service. We reviewed the provider's action plan and information they had provided to us following our last inspection. We also reviewed any notifications and safeguarding alerts we had received. A statutory notification is information about important events which the service is required to send to the Commission by law.

During our inspection we looked at the arrangements for the management of medicines. We spoke with the registered manager, two nurses and three care staff. We observed medicine administration on both the ground floor and first floor. We also looked at policies and procedures, medicine administration and management records and audits. We followed five people's care through their care plans and records, their medicine records, observations of their care and discussions with staff.

Following our visit we requested further information from the provider and registered manager regarding governance and quality systems. This was provided within the timescales we asked for.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection on 23 November 2015 we identified a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Safe care and treatment. This related to observations that members of nursing staff failed to ensure that medicine had been administered before signing the medicine administration record and observations of medicines which had been left on a table and were not fully supervised. Following the inspection the provider submitted an action plan telling us what they would do to put this right.

At this visit we observed nursing staff undertake medicine administration on both the ground floor and first floor. We saw that improvements had been made to address the issues we identified at the last inspection. We saw two nurses giving people their medicines. They followed safe practices and treated people respectfully. People were given the time that they needed to take their medicines. Where someone refused to take their medicines the staff member was able to explain the person's needs and preferences and how they would return to try again later. We observed that the nurse returned to the person several times and eventually ensured that their medicine was administered.

Arrangements were in place for recording the administration of oral medicines, but improvements were needed in the records and guidance for topical medicines. We found examples where we could not be sure what topical medicines people should be receiving from their records and staff were not able to give a clear and consistent description of what topical applications people needed. When we further explored the impact this had on people's care and wellbeing we did not find that this lack of clarity had resulted in any harm to people. For example, we looked at the care of two people who were prescribed creams to help maintain their skin integrity and found that both people's skin was intact. However, it is important that staff have clear instructions regarding the use of topical applications and that administration records demonstrate that topical medicines have been administered in accordance with prescribing instructions.

We found that where medicines were prescribed to be given 'only when needed,' the individual when required guidance to inform staff about when these medicines should and should not be given, was not always available. Whilst the nurses were able to tell us how the medicines were given, this information was not recorded in detail. This information would help to ensure that people were given their medicines in a safe, consistent and appropriate way.

Two people were prescribed medicine administered through a transdermal patch. This meant the medicine was applied to their skin and it is absorbed over time. There was no system in place for recording the site of application. This is necessary because the application site needs to be rotated to prevent side effects.

Some people had medicines administered covertly. This is when medicines are given in food or drink to people unable to give their consent or refuse treatment. We saw that the GP had authorised covert administration for people who did not have capacity and were refusing essential medicines. However, the information on how this would be done was not clear and there was no information to confirm that guidance had been sought from the pharmacist to make sure that these medicines were safe to administer

in this way. This information would help to ensure people were given their medicines safely when they were unable to give consent.

The policy for medicine administration had been recently reviewed by the registered manager. However, it did not cover all aspects of medicine management as recommended by the NICE (National Institute for Health and Care Excellence) guidance: Managing medicines in care homes.

These findings evidenced a repeated breach of Regulation 12 Heath and Social Care Act (Regulated Activities) Regulations 2014.

Medication kept at the home was stored safely. Appropriate checks had taken place on the storage, disposal and receipt of medication. This included daily checks carried out on the temperature of the rooms and refrigerators that stored items of medication. Staff knew the required procedures for managing controlled drugs. We saw that controlled drugs were appropriately stored and signed for when they were administered.

Discussions with staff and review of records found no evidence of any serious medicine errors occurring which had resulted in harm or potential harm to people using the service. Staff had received competency checks and observations of their practice to help ensure they administered medicines safely. The registered manager was also in the process of working with their pharmacy provider to implement an electronic medicine administration recording system. They hoped this would further improve practice.

Requires Improvement

Is the service well-led?

Our findings

At our last comprehensive inspection on 23 November 2015 we identified a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Safe care and treatment. This related to the safe administration of medicines. During this focused inspection we identified that the specific issues raised at the last inspection had been improved, but that other aspects of medicine management required improvement. This meant that we identified a repeated breach of legal requirements. This raised concerns about the effectiveness of the provider's systems for monitoring quality and making improvements.

The service had a manager who had been registered with the Commission since October 2013. They were a registered nurse and had experience of providing and managing nursing services.

The home had a policy for medicine administration, which had recently been reviewed by the registered manager and was provided to us during the inspection visit. We found it did not cover all aspects of medicine management as recommended by the NICE (National Institute for Health and Care Excellence) guidance: Managing medicines in care homes. Following our inspection feedback the manager printed off a copy of the NICE guidelines and added them to the policy and procedure file.

After the inspection we asked the provider about the systems and support they used to update their policies and procedures and ensure they reflected relevant changes to good practice guidance and legal requirements. They told us that arrangements were in place to review and update policies and procedures annually and that this was done by the registered manager. It was the understanding of the registered manager and provider that these documents were up to date. However, there was no formal system to help the manager ensure that relevant changes in best practice guidelines or legislative requirements were appropriately incorporated into the home's policies and procedures at annual review. This was demonstrated by the omissions we found in the policy and procedure for medicine administration.

The registered manager completed a monthly system of audits and checks. We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. We found that the manager and staff had completed regular medication audits and checks, within the monthly audit cycle. However, these were not robust and had not identified the issues we found during this inspection. Where issues were identified during audit there was no action plan in place to address the issues.

There had not been any audits of medicine management undertaken by anyone external to the home since 2013. However, following our inspection the registered manager informed us that they were making arrangements for a support visit from the local Clinical Commissioning Group [CCG] pharmacist. During our visit the registered manager also advised that they were exploring the implementation of an electronic medicine administration record system with their supplying pharmacist and hoped that this would bring about further improvements.

We asked the provider what arrangements were in place to support the registered manager and provide

higher level checks on quality and governance. They told us that they had previously employed the services of an external professional to provide such support. However, the external professional had soon advised that the registered manager and deputy manager had more than 50 years of experience between them and could adequately support to each other. There was currently no formal arrangement to provide external scrutiny to the service other than the support provided by the provider.

The provider told us that they regularly visited Southwoods and had visited in April, June, July, August, September and October 2016. During their visits they observed what was happening at the service and talked with staff, residents and their families to check if everything was fine or if they had any concern.. The provider also described how they telephoned Southwoods three or four times a week and spoke with the nurses, handyman, domestic staff and the administrator. The provider's contact details had been displayed in the staff room for any member of the staff to contact them at any time for support or to report concerns.

Overall these findings evidenced a breach of Regulation 17 Heath and Social Care Act (Regulated Activities) Regulations 2014, and we have required that the provider and registered manager make improvements to ensure that good governance systems are in place.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and manager did not ensure the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and manager did not ensure that effective systems to assess, monitor and improve the quality and safety of the service were established or operated.