Swinton Hall Nursing Home Limited

Swinton Hall Nursing Home Limited

Inspection report

188 Worsley Road
Swinton
Manchester
Greater Manchester
M27 5SN

Tel: 01617942236

Date of inspection visit:
07 June 2017

Date of publication:
08 August 2017

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

This unannounced focused inspection was undertaken on 07 June 2017. At our comprehensive inspection of Swinton Hall Nursing Home Limited on 05 and 06 April 2017 we found the service to be in continued breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with regards to the safe management of medicines. We also found the service in breach of Regulation 17 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance.

We undertook a focused inspection to check 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 Limited on our website at www.cqc.org.uk.

We found continuing concerns about the safe handling of medicines for all 11 people whose records we viewed and there had been no significant improvement in the handling of medicines since the date of the last comprehensive inspection.

These issues meant the service remained in breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, in respect of the safe management of medicines. You can see what action we told the provider to take at the back of the full version of this report.

After our inspection we issued a Possible Urgent Enforcement Action – Section 31 of the Health and Social Care Act 2008 urgent letter asking the provider how they would ensure that people's health would be protected and we required an action plan to be produced within 24 hours. The provider produced an action plan and we held discussions with the manager and provider regarding the plan.

The manager of the home explained in detail exactly how the plan would be implemented, which included less use of agency staff because two new nurses and a clinical lead had been appointed and had started their induction in the home since the date of the last inspection. The plan also included new systems and processes being put in place to check medicines were given correctly; these systems had not previously been in place.

We were assured by the provider that they took the management of medicines very seriously and that they would work hard to make sure people were safe and protected against the risk of poor medicines management.

We also had assurances from NHS Salford Clinical Commissioning Group (CCG) that it was the intention of NHS Salford CCG to encourage and promote partnership working with Swinton Hall to support any improvements they are required to make.

As a result of the action plans submitted to the Commission and the assurances from the CCG no further

enforcement action will be taken at this time in order to allow the necessary improvements to be made.

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

The service was not consistently safe.

At this focussed inspection we checked to see what improvements had been made with the management of medication. We found that people were still not protected against the risks associated with the unsafe use and management of medicines.

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.

This inspection was completed to check that improvements to meet legal requirements after our comprehensive inspection on 05 and 06 April 2017 had been 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 legal requirements in relation to this questions at the previous inspection.

The inspection was undertaken by a pharmacist who is a medicines inspector from Care Quality Commission (CQC).

We looked at medicines and records about medicines for eight people and looked at records about creams for a further three people. We spoke with the manager and nursing staff.

At the time of the inspection there were 33 people using the service.

Inadequate

Is the service safe?

Our findings

We inspected the home on 28 April 2016, 12 July 2016 and 05 and 06 April 2017 and found continuing breaches in relation to the safe management of medicines at each inspection. We issued a number of legal notices, including a Warning Notice, a Notice of Proposal and Notice of Decision identifying to the manager and the service provider that improvements must be made in respect of the safe handling of medicines.

On 07 June 2017 a pharmacist who is a medicines inspector with the Commission visited the home to see if the necessary improvements had been made to ensure that people were protected from the risks associated with the safe handling of medicines. At this inspection we found continuing concerns and the service was still in breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at medicines and records about medicines for eight people and also looked at records regarding creams for a further three people. We found continuing concerns about the safe handling of medicines for all 11 people and there had been no significant improvement in the handling of medicines since the date of the last comprehensive inspection.

Several people had had their medicines reviewed by their GP and the GP practice had sent written details of changes, which needed to be made to the home. We saw that nurses had not taken any action as a result of the new directions which meant that people were given the wrong doses of their medicines or in the case of new medication they were not given it at all. There was no robust system in place to ensure nurses were aware of the changes and there were no checks in place to ensure the new doses were given.

One person was prescribed insulin and there was clear information written down for nurses to follow detailing the circumstances when insulin must not be given. We saw that on a number of occasions nurses administered insulin when it was unsafe to do so which placed that person's health at risk of harm. There were no robust systems in place to ensure that the nurses were following the directions of the diabetic team and there were no checks made by the manger to ensure insulin was given safely.

We saw one person had missed being given their very strong pain relieving patch for six days. The system that was in place to ensure people were given weekly medicines on the right day was not robust. This meant that the person could have been in unnecessary pain for six days.

When we compared the stock levels of medicines to the records relating to them we saw that people had not been given some of their medicines such as anticoagulants and antibiotics and this placed their health at risk of harm. There was no system in place to check stock levels on a regular basis to ensure medicines were given safely.

As found at previous inspections we saw medicines were still not administered in accordance with the manufacturers' directions regarding food. 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.

Some medicines such as paracetamol must be given with at least four hours between doses. As found at previous inspections we saw that nurses failed to record the time they had given doses of paracetamol so it was impossible to tell when the next dose was due and that there was a safe time interval between doses.

Nurses applied some creams but failed to follow the directions carefully; two people were prescribed creams to be applied three times daily but nurses only applied the creams twice daily. There were no robust systems in place to check creams were being given properly.

As found at previous inspections medicines were not ordered in a timely manner and people had run out of medication. We saw people had run out of analgesics and laxatives for three days which could have caused them unnecessary pain or discomfort. No explanation could be offered as to why these medicines had not been ordered in time. The system for ordering medicines was not robust and there were no checks to ensure that medicines did not run out.

We saw that one person administered one of their prescribed medicines under direct supervision of the nurses. However the stock count showed that they had taken too many doses of their medication and there was no robust system in place to ensure they were taking the correct dose of medication.

Some people needed to have their medicines crushed before taking them. As found at previous inspections we saw that nurses still had not sought and recorded advice from a pharmacist to ensure it was safe to crush all their medicines.

Some people required their medicines to be given covertly by disguising it in their food or drink; there was still no information recorded to guide nurses as to how medicines should be disguised. No advice had been sought from the pharmacy if it was safe to hide medicines in hot drinks or with certain foods.

As found at previous inspections the quantities of medication held in the home for each person were inaccurate. This meant that audits and checks could not be done to identify that all medicines had been given as prescribed. There were gaps and missing signatures in medicines administration records (MAR's) or the signatures were unclear, which meant it was not possible to tell if medication had been given properly. A number of people did not have photographs on their medicines records to help new and agency nurses identify them which meant they could be at risk of being given the wrong persons medicines. No explanation could be offered as to why the records were not accurate.

People were prescribed medicines to be taken 'when required' (PRN) including medicines prescribed for symptom relief at the end of life. However as found at the last inspections there was either no information or limited guidance to guide staff when administering some of the medicines which were prescribed in this way.

As found at previous inspections the maximum fridge temperature recorded each day was frequently higher that it is safe to store medicines that must be kept cool. The room temperature was also consistently recorded higher than the recommended maximum temperature for the storage of medicines. We saw there was an air-conditioning unit in the room but it was not effective.

Although improvements had previously been made in the safe storage of waste medicines, this had not been maintained and they were not stored safely at this inspection.

These issues meant the service remained in breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, in respect of the safe management of medicines. You can see what action we told the provider to take at the back of the full version of this report.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe or unsuitable management of medicines. Regulation 12 (2)(g)