Nugent Care

Margaret Roper House

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 21 September 2016 and 18 October 2016 when we found two breaches of regulation. One was a continued breach regarding the management of medicines and one a breach in respect of a lack of monitoring arrangements for medicines. At this inspection we found a number of improvements however people were still not fully protected. This was because the provider's arrangements to manage medicines were still not consistently followed.

We asked the provider to take action to address these concerns. The provider submitted a provider action report which told us the improvements they had made to meet this breach.

We undertook a focused inspection on 8 March 2017 to check that they had they now met legal requirements. This report only covers our findings in relation to the specific area / breach of regulation. This covered two questions we normally asked of services; whether they are 'safe' and 'well led.' The question 'was the service effective', 'was the service responsive' and 'was the service caring' were not assessed at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Margaret Roper House on our website at www.cqc.org.uk.

There was a registered manager in post at the time of our inspection. 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.

Margaret Roper House is a nursing home registered to accommodate people who have mental health care needs. The accommodation is registered for 23 people. The home is owned by Nugent Care.

At this inspection we found a number of improvements. For example, medicine stocks were well controlled, Medicine Administration Records (MARS) were fully completed, the quantities of medicines received into the home and carried forward to the following month was clear and fully documented. The home had introduced a system in the medicines room to highlight to nurses, which medicines were to be given before breakfast and the medicine room was tidy and well organised. Regular medicine audits were also being completed to help assure the safe management of medicines.

We found however concerns around the management of medicines for people outside of the care home. For example, people going on 'home leave' or for trips out from the care home. For two people out on a trip during the inspection they had not received their medicines. For one person their medicine had been removed from the medicine trolley for it to be destroyed. The registered manager told us care staff were unable to administer medicines as they had not been trained to do so. For the two people who did not receive their medicines there was no record in their plan of care or record of discussion with GP around not

giving their medicines as prescribed. One of the two people went out on 'home leave' and we found records of medicines being destroyed and again no record in their plan of care as to why this had occurred.

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

Medicine audits (at service and senior management level) were completed, however, monitoring and audit arrangements for supporting people to receive their medicines when outside of the care home were not robust to assure people's health and wellbeing. The existing audits and governance arrangements had not identified the shortfalls we found during the inspection.

This is a continued breach of Regulation 17 (1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of this 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 was not always safe.

At this inspection we found a number of improvements had been made for the safe management of medicines though people were still not fully protected. This was because the provider's arrangements to manage medicines for people when outside of the care home were not followed.

Is the service well-led?

Requires Improvement

The service was not always well led.

Medicine audits were completed however monitoring arrangements for supporting people to receive their medicines outside of the care home were not robust to assure people's health and wellbeing. The existing audits and governance arrangements had not identified the shortfalls we found during the inspection.

Margaret Roper House

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 checked 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.'

The inspection team consisted of an adult social care inspector and pharmacy inspector.

Before our inspection we looked at the notifications and other intelligence the Care Quality Commission had received about the service. We contacted one of the commissioners of the service to seek their feedback about the home.

During the inspection we spent time with registered manager, a member of the care team and a trained nurse. We also spoke with the head of quality by telephone.

We reviewed the management and monitoring arrangements for medicines at the service.

Requires Improvement

Is the service safe?

Our findings

We had previously visited this home in November 2015, April/May and September/October 2016 and found the home to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the previous visit the quantity of medicines were not always carried forward on the Medicines Administration Record Sheet (MARS), which made it difficult to tell how much medicine should have been present in the home; medicines were not always given as prescribed by the doctor and medicine audits had failed to highlight the lack of documentation of medicine being carried forward.

At the inspection in September/October 2016 we followed up on our enforcement action as we had previously issued a warning notice to the service for the continued breach around the safe management of medicines. At the September/ October 2016 inspection we found a number of improvements had been made however people were still not fully protected. The quantity of medicines were not always carried forward on the Medicines Administration Record Sheet (MARS), which made it difficult to tell how much medicine should have been present in the home. Medicines were not always given as prescribed by the doctor and medicine audits had failed to highlight the lack of documentation of medicine being carried forward. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider to take action to address these concerns. The provider submitted a provider action report which told us the improvements they had made to meet this breach.

At this inspection we checked on the improvements made. There were 21 people living in the home and two people who had come for a trial stay. Four of the people living in home had gone on a day trip with a senior carer and activities person. We looked at the medicines and records for six people living at the care home and spoke with the registered manager, the head of quality (on the telephone), one registered nurse and a carer.

We saw a number of improvements in respect of the management of medicines. In comparison to previous inspections the medicines room was clear, tidy, well organised and the amount of medicines in stock was not excessive. MARS were fully completed and the quantities of medicines received into the home, carried forward to the following month was clear and fully documented. The home had introduced a system in the medicines room to highlight to nurses, which, medicines were to be given before breakfast, and this was clear to follow.

Two of the people that we looked at had gone on the trip out for the day. Both people had medicines to be given at lunchtime and included an eye drop for dry eyes, a medicine for the immune system and a heart medicine. The registered nurse had removed the lunchtime medicine from the medicine trolley for it to be destroyed. When we spoke to both the registered manager and registered nurse, they told us that the carer was unable to administer medicines on days out as they had not been trained to do so. We found that the person on the heart and immune system medicine had left the home on six occasions on day trips or to visit family. On all six occasions their medicines were not given to take at lunch and were destroyed. We checked

the care plan and daily notes for both people and found no risk assessment had been completed and there was no evidence that a discussion with a doctor or the person's family had taken place.

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

Following our inspection we contacted the nominated individual (who has overall responsibility for supervising the management of the regulated activity, and ensuring the quality of the service provided) regarding the arrangements in place to support people with their medicines when away from the home. They told us that carers at Margaret Roper House had been trained to administer medicines when people were on leave and they were not aware of this happening. They also told us there were policies and procedures in place for the safe management of medicines for people who were for example, going out on a trip or going home/holiday.

The head of quality and head of learning and development for the organisation attended the service the day after the inspection and have since sent us an action plan for Margaret Roper House, along with copies of supporting documents which are in place to support people with their medicines outside of the care home. The head of quality was able to confirm that contact was made to external health professionals regarding the health of the people who had not received their medicines on the trip out. They were able to report that these checks were found to be satisfactory.

Requires Improvement

Is the service well-led?

Our findings

We had previously visited the home in September/October 2016 and found the home in breach around the monitoring arrangements for medicines. Although a number of significant improvements had been made regarding the management of medicines the current auditing arrangements for medicines had not picked up on the shortfalls we identified during this inspection. The weekly medicine audit had failed to record the detail of quantity of medicines in the home. This was a breach of Regulation 17(1)(2)(b) of the HSCA 2008 (Regulated Activities) Regulations 2014.

We asked the provider to take action to address these concerns. The provider submitted a provider action report which told us the improvements they had made to meet this breach. We also met with the nominated individual to discuss our findings from the inspection and received regular audits of how medicines were being managed.

At this inspection we checked on the improvements made. We found although there had been a number of improvements around the service's governance arrangements for medicines by completing medicine audits, monitoring arrangements (at service and senior management level) for supporting people to receive their medicines outside of the care home were not robust to assure people's health and wellbeing.

The audits had failed to identify the destruction of medicines when a person was on leave or, to check on how people's medicines were administered to them by the staff when taking part in a trip out. There appeared to be a lack of oversight within the service and also at senior management level in respect of how this was managed and whether it was compliant with Nugent's Care's policy and procedure for medicine support outside of the care home. The existing management arrangements meant people were placed in the position of not having their prescribed medicines when away from the care home, or having to refuse medication because they were away from the care home.

The existing audits and governance arrangements within the service and at senior management level had not identified the shortfalls we found during the inspection.

This is a continued breach of Regulation 17(1) (2) (b) of the HSCA 2008 (Regulated Activities) Regulations 2014.

Following the inspection were provided with an action plan drawn up by the nominated individual, head of quality, registered manager and head of training and development to ensure the safe management of medicines for 'medication taken away from the home' and that the medicines were given in accordance with Nugent Care's policy. The action report provided evidence of how medicines training for staff was going to be developed by means of shadowing and mentoring staff to ensure they have the skills and expertise to support people with their medicines outside of the care home. We were told that care staff had attended medicine training, however, there was recognition that staff needed further support to undertake this practice; the goal being to 'deliver medication via key care workers'.

Nugent Care's policy and procedure for supporting people outside of the care home had been reviewed with the staff along with documentation for staff to record. We were told, 'The way medication will be administered for people away from the home. This includes: Those service users who regularly go on home leave or visit relatives/carers or on holiday, those service users who attend activities and are accompanied by a member of staff and those service users who leave the home unaccompanied to attend activities or other personal reasons (these can be unplanned)'.

We have been assured by the measures taken by the service following our inspection however, we will continue to closely monitor and work with the service and the organisation's senior management team regarding medicine management.

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 We found poor practice around supporting people with their medicines outside of the care home. This is a continued breach of Regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014.

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 We found shortfalls around the management and governance arrangements of medicines for people outside of the care home. This is a continued breach of Regulation 17(1) (2) (b) of the HSCA 2008 (Regulated Activities) Regulations 2014.