St. Matthews Limited

Maple Leaf House

Inspection report

1 Dunsmore Avenue
Coventry
West Midlands
CV3 3AG

Tel: 02476303682
Website: www.stmatthewshealthcare.com

Date of inspection visit:
19 July 2016

Date of publication:
31 August 2016

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good

Summary of findings

Overall summary

Maple Leaf House is a nursing home which provides care for up to 30 people. This includes older people, younger adults and people with mental health conditions including dementia. On the day of our visit there were 16 people living there.

The home had a manager but they were not registered with us. They had been appointed following our last 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.

We carried out an unannounced comprehensive inspection on 25 February and 1 March 2016 at which we identified a breach in the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to medicine management. As a result of the breach of the legal requirements and the impact this had on people who lived at Maple Leaf House, we rated the key question of 'Safe' as 'Requires improvement'. As the provider had not complied with the required standards, we issued them with a warning notice and asked them to improve. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for 'Maple Leaf House' on our website at www.cqc.org.uk.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to the breach. We undertook a focused inspection on the 19 July 2016 to check that they had followed their plan and to confirm they now met the legal requirements. We found the improvements needed to ensure the safe management of medicines had been 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?

Good

The management of medicines was safe.

Medicine procedures had been reviewed. Medicines were stored safely and staff followed safe practice when managing people's medicines.

Maple Leaf 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 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 a focused inspection to Maple Leaf House on 19 July 2016. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 25 February and 1 March 2016 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 that question.

The inspection was carried out by one pharmacist inspector and was unannounced.

We did not ask the provider to complete a Provider Information Return (PIR) prior to this inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not request this form because this inspection was focussed on the safety aspect of medicine management only. Before the inspection, we reviewed all the information we held about the provider. This included information shared with us about medicine management from the Local Authority and statutory notifications received from the provider.

During our visit, we spoke with the manager about what improvements they had made to medicine management. We looked at how medicines were stored and we viewed seven people's medicine records.

Good

Is the service safe?

Our findings

At our comprehensive inspection on 25 February and 1 March 2016 we found the provider did not ensure that medicines were managed safely in the home. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 - Medication. At our focused inspection on 19 July 2016, we found the provider had made the necessary improvements to ensure safe medicine management in the home.

We looked at how medicines were handled which included looking at seven people's Medicine Administration Record (MAR) charts. We found the new arrangements for medicine management were safe and person centred. One staff member told us ''It is a new system which, although a bit time consuming at times, is working very well.''

People's medicines were labelled individually and kept secured in locked medicine trolleys. The keys for medicine storage were held by the nurse in charge. Separate storage facilities had been arranged for controlled drug medicines that required special and secure storage. Medicines were stored within the recommended temperature ranges so they remained effective. Daily temperature records were available to confirm the medicine refrigerator and the medicine room were within the recommended temperature range.

Sufficient supplies of people's medicines were available to treat their diagnosed health conditions. MAR charts were completed to document that people had been given their prescribed medicines or a reason was documented to explain why a medicine had not been given. We observed a nurse administering medicines from the medicine trolley. This was carried out following safe practice to ensure the correct medicine was administered and recorded on the person's MAR chart.

We found that arrangements were in place for accurate medicine stock checks. This meant it was possible to check the balance of all medicines to ensure they had been given as prescribed. We found that all the balances we checked were accurate.

Supporting information for staff to safely administer medicines was available and easily accessible. There was a clear record showing staff the site of medicine patch applications on a person's body. This is particularly important for pain relief medicines so nurses are aware where a medicine patch is located. When people were prescribed a medicine to be given 'when required' such as for agitation, supporting information was available to enable nursing staff to make a decision as to when to give the medicine.

Any changes or additions made to people's medicines by a doctor were recorded and kept together with their MAR charts. This information helped the nurses to quickly check that any recent changes had been undertaken.