The Holmes Care Limited

Cranham Court 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

This inspection took place on 4 May 2017 and was unannounced. At the last inspection on 1 November 2016 we found the service to be in breach of the regulation relating to having systems in place to ensure equipment was used in a safe way and for the proper and safe management of medicines. This also meant the provider did not have effective systems and processes to assess, monitor and mitigate the risks to the health, safety and welfare of people in the service.

After the inspection, the registered provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check they had followed their plan and to confirm they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report of our last comprehensive inspection, by selecting the 'all reports' link for Cranham Court Nursing Home on our website at www.cqc.org.uk.

Cranham Court Nursing Home provides accommodation, nursing and personal care for up to 68 people. On the day of our visit, 61 people were using the service. The service is located in Upminster, Essex and is divided into two large units; the Main and Extension unit, which is a nursing and residential unit and the Woodlands unit, for people with dementia.

There was a registered manager in post. 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 the provider had taken sufficient action to ensure medicines were stored, administered, recorded and ordered more effectively, safely and appropriately. We also found that steps had been taken to make sure equipment such as wheelchairs were used more safely by using the footrests on them to move and transfer people.

However, there were still concerns relating to people obtaining and receiving their medicines on time. At our last inspection, we found that some people had missed important doses of medicines for more than one day. This was due to a change in the ordering system between the GP, pharmacy and Cranham Court which caused delays. This meant that some people received their repeat prescribed medicines late. These issues were mostly resolved after the ordering system reverted back to the previous system of ordering monthly instead of three monthly.

Although there were improvements, we noted that one person had missed important medicines for nearly two weeks due to staff not taking sufficient action to obtain their medicines. There was a failure to effectively assess the risks and ensure that the person received their medicines more efficiently, after they were

admitted to the service. We have also made some further recommendations around training in administering certain treatments such as eye drops, creams and ointments.

The service followed safe recruitment procedures to ensure staff were safe to provide care to people and had carried out recent Disclosure and Barring Service checks for long serving staff.

There were improvements in communication among staff from each unit to share good practice. The registered manager demonstrated an understanding of their role and responsibilities. We noted a range of weekly and monthly audits, including medicine and health and safety checks. However, we found there were still ineffective systems to routinely monitor the safety and quality of the service provided that ensures all people's needs are met.

We identified one continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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. We have not changed the rating for Safe because there were still some issues relating to people missing medicines for long periods and we have made some further recommendations.

Action had been taken by the provider to make improvements. Systems were in place to support people to receive their medicines safely. Medicines were administered, stored and managed more appropriately.

Equipment was safe to use and transfer people. Appropriate checks had been undertaken to ensure staff were suitable to work with people who used the service.

Is the service well-led?

Requires Improvement

The service was not always well led. We have not changed the rating for Well Led because we had concerns that the systems and processes to assess, monitor and mitigate the risks to the health and safety of people were still not effective enough. This was because the provider delayed taking action to obtain a person's medicine.

Action had been taken to improve the management and monitoring of the service and the registered manager had developed more robust procedures.

People and relatives were able to provide feedback to the service. Staff felt supported and said they could approach the management team.

Cranham Court 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 inspection was undertaken to check that the provider had made improvements to meet legal requirements after our inspection on 1 November 2016. We inspected the service against two of the five questions we ask about services: Is the service Safe? And Is the service Well Led? This was because the provider did not have effective systems and processes to assess, monitor and mitigate the risks to the health, safety and welfare of people in the service, such as with the management and administration of medicines.

This inspection took place on 4 May 2017 and was unannounced. It was undertaken by one adult social care inspector and a pharmacist inspector.

Before our inspection we reviewed information we held about the service and the provider. This included the action plan the provider submitted setting out how they would become compliant with the breaches identified at the previous inspection. We also received feedback from the local authority and Healthwatch. We spoke with the registered manager, the deputy manager, who was a registered nurse, eight staff and with two relatives. We looked at the records staff training, a range of quality assurance, health and safety audits, medicine charts and procedures.

Requires Improvement

Is the service safe?

Our findings

During our inspection, we saw evidence of actions the registered manager had taken to address the concerns we had identified. At our inspection in November 2016, we found there were shortfalls relating to medicines management and this also identified some concerns about how the service was managed overall.

For example, on both units we found some people had not received medicines for two days due to a change in the ordering system, between the local pharmacy and the regular GP. This resulted in medicines not being delivered on time and meant that people missed doses of important medicines which could have a negative impact on their health. We also found concerns related to the inconsistency of recording on Medicine Administration Recording (MAR) charts and with the management of covert medicines. During this follow up inspection, we saw that most of these issues had been addressed, although there were some areas that required further improvement.

We noted that regular medicines were supplied by the pharmacy to the service on a monthly basis, instead of the previous three monthly cycle, which had caused the previous issues. Most tablets and capsules were dispensed into a monthly monitored dosage system or into individual boxes. All medicines were prescribed by a GP who visited the service each week. If a medicine was required urgently, an on call GP supplied a prescription which was dispensed immediately at a local pharmacy. Prescriptions were generated and sent electronically to a local community pharmacy who delivered them to the service.

We checked medicine storage, supplies and MAR charts for ten people. Most of the prescribed medicines were available, and where they were not, we saw that an attempt had been made to obtain the medicines by following the provider's procedures. However, we found that after one person was admitted to the service, three medicines were missing from those listed on their hospital discharge letter. We saw that staff had made initial efforts to obtain the missing medicines but had not followed up to ensure all the medicines were delivered. On the day of the inspection, we noted the person had missed one of the medicines for 11 days and two for 13 days each. One of the medicines was used to treat symptoms of gastroesophageal reflux disease (GERD) and other conditions caused by stomach acid. This meant that they missed vital doses which could have had a serious impact on their health. The deputy manager said, "The hospital made a mistake and assumed [the person] was going back to their previous nursing home. This caused delays with the medicines."

We recommend the provider reviews how missed doses of medicines are dealt with at any given time.

Where people had been prescribed medicines to be administered on a 'when required' (PRN) basis, we saw two other examples of medicines that were not available at the service at the time of this inspection. For one medicine, staff told us they had ordered it and were awaiting its arrival. For the other medicine, which was to treat hay fever symptoms, we noted that the GP was debating on whether it was still required to be taken by the person. Although there were no missed doses, we advised that PRN medicines are always kept in stock should people require them at any time.

Nursing staff had access to the clinical rooms where medicines were stored which were kept locked. We found that all medicines were stored in locked cabinets or trolleys within the clinical rooms. The clinical rooms were clean with hand washing facilities available. At our previous inspection, we did not see sufficient records of room and refrigerator temperature checks where medicines were stored in accordance with manufacturers' guidelines to retain their effectiveness. At this inspection, we saw that improvements had been made and staff recorded the ambient room temperature of the clinic rooms daily. Staff also recorded the minimum, current and maximum refrigerator temperatures, and reset the thermometer every day. There was one occasion when one refrigerator increased to 14°C and appropriate action was taken by staff to ensure that the fridge was repaired and working properly. The temperature readings provided assurance that medicines were stored at the correct temperatures to remain effective.

We saw improvements had been made in the recording of medicines once they were administered by the registered nurses. We observed people's medicines being administered and noted that nursing staff followed procedures to ensure it was done safely and hygienically. People were offered a drink with their oral medicines and were observed taking their medicines. The administration was recorded on the MAR chart immediately. The deputy manager told us that nursing staff received medicine administration training from the local pharmacist and through e-learning. The application of creams and ointments were carried out by care staff and the MAR charts were annotated with the letter 'C' to indicate this. However, we found that care staff were not formally trained on the administration of creams and ointments.

We recommend a review of training for care staff regarding the application of creams and ointments.

One person was viewed having two different eye drops administered at the same time of day in the same eye. The nursing staff did not leave a short gap in between the administration of the two eye drops so as not to dilute their effectiveness, as advised in the British National Formulary (BNF). We recommended that staff follow guidance from the BNF around the administration of eye drops.

The MAR charts we viewed provided assurance that residents were receiving their medicines safely, consistently and as prescribed. We saw improvements in the management of covert medicines. Covertly given medicines are hidden in food or drink without the knowledge of the person. We saw records of best interest decisions around the use of covert medicines administration written by the nurses, and signed by a GP, a pharmacist and the person's next of kin.

Controlled drugs (CDs) were stored in each clinical room in a CDs cabinet. We saw that the stock levels for CDs were checked weekly or monthly by nurses. We checked three of the CDs during this inspection and saw the quantity of CDs in stock matched the quantity recorded in the CD register.

Staff had access to medicine disposal facilities. Unused medicines were stored in a clinical waste bin and returned to the local pharmacy each month. Sharp objects, such as needles and syringes, were disposed of into a sharps bin. Staff made appropriate records of medicines that were disposed of, including CDs that were denatured or expired.

At our previous inspection, we observed people being transferred from a chair to a wheelchair without the use of footplates, which put people at risk of injury. We looked at how the provider had addressed this issue and saw that there was an appropriate wheelchair policy in place to ensure staff used them safely. All wheelchairs had been checked and serviced to ensure footplates were suitable and working. We saw staff and people use the footrests appropriately and that the registered manager had sent notices to remind all staff of their responsibilities to use equipment safely.

The provider had safe recruitment processes in place and had taken on board our recommendation at our previous inspection to carry out Disclosure and Barring Service (DBS) checks on longer serving members of staff. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with people using the service. It is good practice for providers to carry out these checks on existing staff every three years. The provider confirmed that 15 members of staff had recently applied for checks and most had been completed at the time of the inspection.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection, we identified a breach of the regulation for providers to have effective systems and processes to assess, monitor and mitigate the risks to the health, safety and welfare of people in the service. This was because within both units of the service, people missed important doses of medicines, staff did not maintain sufficient records of these incidents and MAR sheets were not always completed correctly. We also noted a lack of effective communication between the two units that would enable staff to share learning, concerns and good practice.

During this inspection we saw that some improvements had been made. We saw that MAR charts were checked daily to ensure that they were completed appropriately. Quality assurance and monitoring systems were in place to ensure the safety of people within the premises. For example, both the Main unit and Woodlands unit maintained up to date records of accidents, incidents, falls and risk assessments. The provider had systems in place to seek the views of people and their relatives. We saw records of meetings between senior staff within each unit and a communication book for the management team to note any concerns that occurred during the day and share important information. Staff also attended meetings each month and this was confirmed by the records we looked at.

Following our last inspection, the registered manager had introduced incident reporting forms for dealing with medicine incidents, such as errors or missed doses. At this inspection, we found that one person had missed important medicines after being discharged to the service from hospital on 21 April 2017. Their full allocation of prescribed medicines was not received until the day of the inspection on 4 May, which meant that they had gone without their medicine for nearly two weeks. We looked into what action staff took to ensure the medicines were ordered and collected. Records showed that steps were taken by staff to obtain the missing medicines on 21 April and some were delivered. However, some medicines were still missing and further action was delayed, without reason, until almost a week after the person was admitted to the service, before eventually arriving on the day of the inspection.

The management team told us this was a systemic issue after people were discharged from hospital and were admitted to the service for the first time, as the hospital did not always send the service a full supply of medicines. This meant staff in the service were placed with the responsibility of ensuring the hospital or GP was contacted. Medicines alerts were usually received by the registered manager through emails from senior staff. If they were important, they were communicated to all staff, although on this occasion an alert was not received. The registered manager said, "Staff should have contacted the hospital to get the remaining items but it was not chased up." We advised the registered manager to raise a safeguarding alert with the local authority to notify them of the incident and what action was being taken to ensure the person remained safe.

We noted that staff conducted and completed monthly medicines audits. However, the actions identified in the audit were not always progressed. For example, the audit had recommended staff complete weekly Controlled Drugs checks on the Main unit. We noted that staff had not implemented this and were still doing it monthly. The audit also identified that some people had a photograph missing from their MAR chart and

on the day of inspection, this was still the case.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt well supported by the management team. One member of staff said, "I have been here for less than two years as a permanent member of staff. It is good and we get lots of support and guidance from Matron [registered manager] and the deputy manager. They are very helpful." People and relatives were also happy with the service and one relative told us, "I have been very impressed. The staff are kind. They sit and find time to talk with my [family member]. My [family member] really likes it here."

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always assess, monitor and mitigate the risks relating to the health, safety and welfare of people. Regulation 17(1) (2)(b)

The enforcement action we took:

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