Harbour Healthcare Ltd

Hilltop Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	**Requires Improvement**
Is the service responsive?	**Good**

Summary of findings

Overall summary

This was an unannounced focused follow up inspection, which took place on 25 April and 3 May 2017.

At our last inspection on 31 August and 1 September 2016, we found two breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment and person centred care.

Following the inspection the provider sent us a plan of the actions they intended to make to meet the relevant regulations. This inspection was carried out to check that the provider had met the breaches in the regulations. This report only covers our findings in relation to this topic. You can read the report from out last comprehensive inspection by selecting the 'all reports' link for 'Hilltop Court Nursing Home' on our website at www.cqc.org.uk.

Hilltop Court Nursing Home provides accommodation for up to 50 people who live with advanced dementia. There were 47 people using the service at the time of our visit.

The service had a registered manager in place, though they were not available 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.

At our last inspection, we found two breaches in the regulations related to the management of medicines and the lack of religious and cultural preferences on people's care and end of life plans. Following the inspection the provider sent us a plan of the actions they intended to take to meet the relevant regulations.

At this inspection, we found that although significant improvements had been made the service was in continuing breach of the regulations in relation to medicines management. The breaches related to, incomplete medicines administration records (MAR), the arrangements for administering medicines covertly in food, the lack of 'when required' PRN protocols and temperatures to the medicines fridge temperatures.

You can see at the back of this report what we have asked the provider to do.

At this inspection, we found that the records relating to people's religious and cultural preference had improved. Care records had been put onto a new electronic system and were accessible to staff at all times via laptops iPads, although the iPads were not operational during our visit. We were informed that 25 advanced care plans had been completed and the outstanding advance care plans were on-going with arrangements being made with families or solicitors. We were also informed that a Greater Manchester Ambulance Service liaison officer was also coming in to talk to families and relevant others of people who use the service. We recommend that the service completed the remaining records as far as practicably

possible to do so.

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.

Although improvements had been made, we found medicines were not always managed safely.

Is the service responsive?

Good

The service was responsive.

Care plans were now accessible to staff. On-going improvements had been made to ensure care plans reflected people's religious and end of life preferences.

Hilltop 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 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.

This inspection took place on 25 April 2017 and was unannounced and was undertaken by an adult care inspector and a pharmacist inspector. The pharmacist inspector returned to the home 3 May 2017.

Before our inspection, we checked the action plans sent to us which informed us of what action the service intended to take to make improvements to the breaches we found.

During this inspection, the registered manager was unavailable so we spoke with the quality care lead, a peripatetic nurse and operations support manager. We looked at medicines management, including the medicines administration records for twenty people and four people's care records.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection, we found that the home was in breach of regulation 12, the proper and safe management of medicines, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we checked whether improvements had been made to the management of medicines.

We observed staff give people their tea-time medicines and saw that medicines were administered in a safe and friendly way. We looked at the medication administration records (MARs) belonging to 20 of the 47 people living in the home and found a total of eight 'gaps' in three people's records. This meant that their record did not show whether or not they had received that dose of medicine.

It is good practise to provide staff with extra guidance in the form of a PRN protocol when a person is prescribed a medicine to be taken only 'when required'. This ensures that the person gains maximum benefit from the medicine and it is used safely. Only half of the people whose records we saw, who had been prescribed one or more medicines to be taken 'when required', had a protocol containing adequate information on how their medicine should be used.

We saw that one person was prescribed a thickener as they needed all their liquids to be thickened due to swallowing difficulties. The consistency required was written on their MAR. This reduced the risk of the person choking. Some people were given their medicines disguised in food or drink. This had been agreed by their doctor after an assessment of their ability to understand the importance of these medicines for their health. However, the pharmacist had not been asked which foods and drinks could be mixed with the medicine safely to ensure this did not reduce the medicine's effect. The manager contacted both the doctor and the pharmacist who supplies medicines to the home for advice on how to disguise people's medicines safely immediately after the inspection.

The application of people's prescribed moisturising and barrier creams by carers was poorly recorded. This meant that records did not show if people's skin was cared for properly. Controlled drugs, medicines subject to tighter controls as they are liable to misuse, were kept safely in a cupboard that complied with the law. We checked the stock balances of five controlled drugs with the records and found that the quantities were correct. Staff checked the controlled drugs each day.

Medicines were kept safely and medicine cupboards were clean and tidy. The home's records for April showed that medicines in the refrigerator were stored at the right temperature. However, the maximum and minimum fridge temperatures recorded for April were well above and below the range for safe storage. The direction by drug manufacturers to 'store in a refrigerator' means they need to be stored in temperatures between two and eight degrees Celsius. If medicines are not kept at the right temperature they can become less effective or unsafe to use.

The home had an up-to-date medicine policy. Managers carried out regular medicine audits (checks) and some issues had recently been identified and acted upon. One drug error occurred because staff did not

read the label of a medicine a person brought back to the home after a stay in hospital.

During this inspection, we found significant improvements in the way medicines were managed, but due to the concerns outlined in this report, we found the home was still in breach of regulation 12.

Good

Is the service responsive?

Our findings

At our last inspection, we found that the service was in breach of the regulation regarding person centered care. This was because the care records we looked at did not include people's religious or cultural preferences and end of life care plans did not highlight the religious wishes and needs which might be needed at the time of their death. We also found that care plans were not always available to staff. It was noted that because people who use the service had advanced dementia the registered manager was reliant on families and other relevant people to complete these plans.

Since our last inspection, we were told by the home's quality care lead that everyone who used the service care records had been put onto an electronic system. We were told that staff always had access to the electronic system through either laptops or iPads. Unfortunately, the iPads were not working at the time of our inspection. This was because the Wi-Fi connection was not working; however, the problem was in the process of being resolved.

We requested to look at four people's records chosen at random. We saw that end of life care plans were in place for two people. This included for one person the family's wish for the person to be seen by roman catholic priest at the end of their life.

We looked at the full care records for two other people. We saw that the care records were very detailed. However, they did not contain end of life care plans. This was because one person had no known family or friends. We were informed following the inspection that the registered manager had a 24 hour phone number for the person's solicitor whilst court of protection arrangements were going though and had also accessed an independent advocate to support the person. Arrangements were still to be put in place for a fourth person with their relatives' agreement.

We were informed that the registered manager had completed 25 end of life care plans, and arrangements had been made to talk to other families and other relevant people. Arrangements had been put in place for the Greater Manchester Ambulance Service (GMAS) liaison officer to come in to talk with families.

We recommended that as far as is practically possible, that the remaining end of life care plans are completed.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely. Regulation 12 (2) (g)