Halton Services Limited

Parkfield House Nursing Home

Inspection report

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Ratings

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

Summary of findings

Overall summary

This inspection took place on 13 November 2015 and was unannounced.

The last inspection of the service took place on 4, 5 and 11 August 2015, where we identified two breaches of Regulation. One breach related to people's care records which although contained information about people's needs they were sometimes contradictory and some lacked sufficient detail. The second breach was a continued breach in the management of medicines. We issued a warning notice telling the provider that they needed to make improvements to medicines management by 30 September 2015. This inspection was to check the provider had made the necessary improvements to medicines management. The other breach of Regulation was not inspected on this occasion.

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.

This inspection looked at how medicines in the service were being managed. We found that the medicines were stored, recorded and administered safely. Staff had received training and support to make sure they administered medicines appropriately. Medicine administration records were accurate and up to date. The staff undertook daily audits of medicines and the registered manager undertook additional monthly audits to ensure people were accurately and safely receiving their medicines. We found the provider had made the necessary improvements and was now meeting the legal requirements in relation to medicines.

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 service was safe. Medicines were managed safely and we found that the provider had put in place effective arrangements to protect people against the risks associated with the management of medicines.

Parkfield House Nursing Home

Detailed findings

Background to this inspection

Parkfield House nursing home provides long term accommodation with nursing care for up to 44 older people. There were 28 people living in the service at the time of the inspection and one person was in hospital.

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 took place on 13 November 2015 and was unannounced.

The visit was carried out by a pharmacist inspector.

The inspection was carried out to check whether the provider had made the necessary improvements to the way in which medicines were managed at the service. During the inspection we met with the registered manager, two nurses and a care staff member. We looked at the medicines, the way they were stored and records relating to medicines, including the administration records for 29 people.

Good

Is the service safe?

Our findings

At the last inspection of the service on 4, 5 and 11 August 2015 we found that people's medicines were not being managed in a safe way. We issued the provider with a warning notice telling them they must make the necessary improvements by 30 September 2015.

At the inspection of 13 November 2015 we found that the provider had made the required improvements. People were receiving their medicines as prescribed and in a safe way.

We assessed how the service was managing medicines for people by looking at medicines audits, medicines records, medicines storage and supplies of some medicines, as people were not able to give us their views on how all aspects of their medicines were managed. We saw that improvements had been made. Processes, audits and records now in place provided assurance that people were consistently receiving their medicines safely and as prescribed.

The registered manager had put a lot of thought and effort into improving how medicines were managed in the service. Arrangements for the supply of medicines had improved. The registered manager had changed the pharmacy supplier, the ordering system for medicines was more effective, and peoples prescribed medicines were available for them. The registered manager had requested the GP to review peoples medicines, and these reviews had taken place. The critical aspects of the medicines policy had been summarised and reissued to staff, including bank and agency staff, who had signed to confirm they had read and understood the policy. Bank and agency staff had also received medicines training. The registered manager had assessed the competency of staff with responsibilities for medicines. They told us that there were sufficient staff on duty to administer medicines to people during the day and at night, and we saw from records that medicines were administered at the correct times.

Medicines records were clearly completed and up to date. There were no gaps on these records. Balance checks of boxed medicines were carried out daily to check for accurate medicines administration. When required, or "PRN" medicines were managed well. Protocols were available for these medicines, to identify when these medicines should be administered to people. Pain assessment records were also now in place, and pain assessments were carried out for everyone prescribed pain relief. Two types of pain assessment were in use, for people able to communicate when they were in pain, and another more detailed pain assessment for people less able to communicate. This all provided assurance that people's pain was managed appropriately.

Medicines were now stored securely and at the correct temperatures and the medicines room was clean and orderly. Safe arrangements were in place to dispose of medicines, including controlled drugs and sharps. Topical medicines application records were in place, and being used, giving care staff instructions on how often and where to apply creams. For people prescribed transdermal medicines patches, detailed records were kept of the site of application, and staff made a record when patches were applied and removed. Mental capacity act assessments and best interests meetings had taken place for medicines which needed to be administered covertly. When medicines needed to be crushed before administration, the method of

crushing tablets was safe, with separate tablet crushers available.

High risk medicines such as, insulin and warfarin, were managed safely. Insulin was stored at the correct temperatures to remain effective. Blood glucose monitoring sheet were in use. Anticoagulant monitoring charts were in use for warfarin so it was possible to check that the correct dose had been administered. Risks due to medicines had been identified, such as if people were prescribed four or more medicines or sedating medicines, which placed them at risk of falls, and these risks were managed. The registered manager had set up folders for medicines and patient safety alerts, and another for medicines information leaflets so that staff had information on medicines. For someone who was under the care of the palliative care team, anticipatory medicines for pain and symptom were kept, to avoid delays in starting treatment. Records were kept of the input by other health professionals, such as the palliative care team, and the GP. When people were admitted to hospital, a record of their medicines was sent with them.

The medication audit template had been updated, and was detailed enough to pick up issues with medicines. The registered manager audited medicines every month. The last two audits showed a high level of compliance. The last audit score was 97%. There was a detailed action plan following on from each audit, and we saw that there was evidence that issues identified were followed up promptly. Daily audits were also carried out by the nurses, to check that medicines had been administered correctly on each shift.

Therefore we found that medicines were now managed safely as there were effective arrangements in place to protect people against the risks associated with the management of medicines.