Four Seasons (No 10) Limited

Murrayfield Care Home

Inspection report

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Ratings

Is the service safe?	Requires improvement

Overall summary

Murrayfield Care Home provides accommodation, nursing and personal care for up to 74 older people some of whom are living with dementia. There are three floors with the second floor providing support for people with dementia.

At the time of this focused inspection there was a new manager in post who has not yet applied to be the registered manager. 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 the last inspection of this service on 11 and 14 September 2015 we found that some aspects of medicines management were not safe and there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Due to the serious nature of the breach we took enforcement action against the registered provider.

After this inspection, the provider wrote to us to say what they would do to meet the legal requirements for the breaches we found. The provider confirmed that they would complete daily and weekly medicine audits on each unit and as part of that process would also review Medication Administration Records (MAR) for each person using the service. The provider also stated that they would review staff medicine training and ensure that all nurses undertook a medicine competency assessment.

We undertook this unannounced focused inspection on 2 December 2015 to check that the most significant breach of legal requirements in relation to Regulation 12, concerning medicines, which had resulted in enforcement action, had been addressed. During this inspection we found that the legal requirements as per Regulation 12 had been met.

This report only covers our findings in relation to this requirement. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Murrayfield Care Home on our website at www.cqc.org.uk.

Summary of findings

We will undertake another unannounced inspection to check on all other outstanding legal breaches identified for this service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

During this focused inspection the service was found to be safe and was following current guidelines as stated in their medicines policy and procedures in relation to the safe management of medicines. However the rating will remain as 'requires improvement' as the CQC need to be assured that the provider will continue and sustain these improvements.

Requires improvement

Murrayfield Care 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.

We undertook an unannounced focused inspection of Murrayfield Care Home on 2 December 2015. The inspection was carried out by a pharmacist inspector.

The inspection was carried out to check that action had been taken to comply with the warning notice as the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We checked the provider's action plan which they sent to us to confirm that the provider had completed the actions that were stated.

Requires improvement

Is the service safe?

Our findings

At our September 2015 inspection we found a number of serious failings in particular areas of medicines management. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People using the service were not safe and we took enforcement action against the registered provider.

The inspection in September 2015 found that the supplying pharmacist had to make up an emergency supply of medicines at the beginning of the cycle to ensure that people had access to and received their prescribed medicines on time. During our focused inspection on 2 December 2015, we found significant improvements had been made to ensure that people received medicines safely and were not at risk due to unsafe practices of improper management of medicines. We saw appropriate arrangements were in place for obtaining medicines. Staff told us how medicines were obtained and we saw that supplies were available to enable people to have their medicines when they needed them. We checked the medicines for 26 out of 42 people and saw no medicines were out of stock.

At the last inspection we saw that Medicine Administration Records (MAR) were duplicated and the same medicines had been signed for on both records. Therefore, we could not be sure that people had received the correct dose of medicines. As part of this focused inspection we looked at a sample of MAR's for 26 people who used the service. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records showed people were getting their medicines when they needed them, there were no gaps on the MAR's and any reasons for not giving people their medicines were recorded.

During the inspection in September 2015 we noted that people may not have been receiving their medicines as prescribed. People's doses of medicines had been changed by the prescriber and we saw that entries had been altered on the MAR by staff. These handwritten entries had not always been signed by a second member of staff, dated or referenced to information from the prescriber. The home's policy for amending doses had not been followed. However, at the recent focused inspection we noted that the MAR was clear and had been completed appropriately.

As part of the last inspection we saw that the home had undertaken internal medicine audits, however, these were not regular or comprehensive and did not pick up any of the serious issues that we found with medicines in the service. During this inspection we saw the provider carried out daily and weekly audits to check the administration of medicines was being recorded correctly. The stock balances for medicines, not in the monitored dose system, were recorded daily and the sample we checked was correct. This meant the provider had systems in place to monitor the quality of medicines management.

In addition to our findings relating to specific issues we also noted the following; controlled drugs were stored and managed appropriately. When medicines were being administered covertly to people we saw there were the appropriate agreements in place which had been signed by the GP, family and pharmacist.

When medicines were prescribed to be given 'only when needed', or where they were to be used only under specific circumstances, individual when required protocols, (administration guidance to inform staff about when these medicines should and should not be given) were in place. This meant there was information to enable staff to make decisions as to when to give these medicines to ensure people were given their medicines when they need them and in way that was both safe and consistent.

Records showed all qualified staff had completed medicines management training in September 2015 and we saw medicines competency assessments had been completed for those staff who administered medicines. Based on the above information that was provided, it was positive to note that the provider had taken the necessary steps to comply with the warning notice and complete the actions stated as per their action plan. However, the rating under the 'safe' domain will remain as 'requires improvement' as the CQC need to be assured that the provider will continue with and sustain these improvements.