Bupa Care Homes (ANS) Limited

Meadbank Care Home

Inspection report

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Ratings

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

Summary of findings

Overall summary

We conducted an inspection of Meadbank Nursing Centre on 4 and 5 April 2016. At this inspection a breach of regulations was found in relation to safe management of medicines. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to this area.

We undertook this focused inspection to check the provider had followed their plan and to confirm that they now met legal requirements in relation to the breach found. We also received some information of concern prior to our inspection which we followed up during this inspection. This report only covers our findings in relation to the above. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Meadbank Nursing Centre on our website at www.cqc.org.uk.

Meadbank Nursing Centre is a care home with nursing for up to 176 people, with a particular emphasis on providing palliative care. There are four units at the home each named after a famous bridge in London and each had its own unit manager. Albert Bridge unit which is based on the ground floor is home to older people with some early onset dementia and Westminster Bridge Unit which is on the first floor is a nursing unit. Chelsea Bridge unit which is located on the second floor is home to those with palliative care needs and Lambeth bridge unit is home to those with advanced dementia needs. There were 157 people using the service when we visited.

There service did not have a registered manager at the time of our inspection. A new manager had been hired and was in the process of registering with the CQC. 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 previous inspection we found that there were some issues with regard to the safe administration of medicines. We found that people being prescribed medicines that were labelled 'do not crush' were having their medicines crushed prior to administration thereby placing them at risk of unsafe administration. Some PRN or 'as needed' medicines protocols were not detailed enough to adequately instruct care staff. We also found that some people with higher than expected blood glucose levels were not being referred for further medical advice or assistance as expected.

At this inspection we found that all people within the home who had their medicines crushed had specific instructions in place from their GP on how to do this and care staff were aware of these. We found people who had medicines administered 'as needed' had protocols in place which instructed care staff as to how and when these could be safely administered. We found people whose blood glucose levels were being checked had their levels recorded and there was an indication on the form as to what safe readings were for the person. Nursing staff were clear about what action to take if people's blood glucose levels were not at a safe level.

There were enough staff employed and scheduled to work to meet people's needs and keep them safe.

Care staff were trained in how to safely move and reposition people with mobility problems. Care plans included instructions for care staff about how to safely move and reposition people and care staff were aware of people's requirements. We observed a person being moved safely in accordance with the details in their care plan.

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

We found improvements had been made to the safety of the service. Medicines were administered and disposed of safely.

People were moved and repositioned safely in accordance with the instructions within their care plans. There were enough staff employed and scheduled to work to meet people's needs and keep them safe.

We could not improve the rating for safe from Requires Improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Meadbank 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 Meadbank Care Home on 2 September 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 4 and 5 April 2016 inspection had been made. The team 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 some legal requirements. We had also received some information of concern which we followed up.
The inspection was conducted by a single inspector and was unannounced.

Prior to the inspection we reviewed the information we held about the service, including any notifications about serious incidents and any changes to the service.

We looked at a sample of eight people's care records and records related to the management of the service. We spoke with six care workers and one nurse.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we found that the provider was not always safely managing medicines. We found that some medicines which were labelled as 'do not crush or chew, swallow whole' were being crushed by nursing staff before administration. This may have placed people at risk of unsafe administration of their medicines. At this inspection we found all people who had their medicines crushed prior to administration had instructions in place from the GP to do so. This confirmed that crushing was appropriate and detailed what type of food or drink the medicine was to be added to.

At our previous inspection we found staff monitored blood glucose levels for people prescribed medicines for diabetes. Although this monitoring was carried out daily, there was no written evidence that staff had taken action when three people's blood glucose readings were much higher than expected. This may have placed people at risk, because poor control of blood glucose levels increases the risk of diabetes complications. At this inspection we found people whose blood glucose levels were checked had these recorded. We found forms contained upper and lower safe reading limits for care staff. Nursing staff were aware of what were considered to be unsafe blood glucose levels for people and what they should do in the event of this happening. We queried some people's blood glucose readings and nursing staff explained how they managed people's health to keep them safe and took appropriate action when people's blood glucose levels were higher than expected.

At our previous inspection we noted that staff did not always record the quantities of disposed of liquid medicines, so staff could not check that these had been used correctly. At this inspection we found the quantities of disposed of liquid medicines were recorded so staff were able to check that these medicines were being used appropriately.

At our previous inspection we found patch application records were in place for medicines prescribed as topical patches, to record the site of application, and evidence the rotation of the patch site to reduce the risk of side effects. However, we noted that the provider's patch application record did not require that staff record if and when the old patch had been removed. We also noted that one person's patch was not rotated every three to four weeks as required on their medicines information leaflet. At this inspection we found the provider's path application record did record if and when the old patch had been removed and records indicated that people's patches were rotated as required.

At our previous inspection we found protocols were in place for medicines prescribed to be given 'as needed' (PRN) such as pain relief, but some of these protocols were not sufficiently detailed. At this inspection we found PRN protocols were sufficiently detailed and contained the required information for care staff to administer these medicines safely.

Prior to this inspection we received information of concern about staffing levels and moving and unsafe moving and handling. However, during this inspection care staff told us they felt there were enough of them on duty to do their jobs properly. Comments included "I can sit with people in the lounge and have a chat" and "There are usually enough staff, except when someone calls in sick. But the nurse will usually get

someone else to come in." The senior nurse told us that senior staff assessed people's needs on admission to determine what their level of dependency was in terms of care and support from nursing and care staff. We saw documentation in people's care records that showed what people's dependency levels were. Staff were then matched according to their skill set and the rota for a particular unit was assessed to ensure the correct skill mix of staff was present at every shift. Each unit was staffed by two nurses and approximately one care worker for every six people except on the palliative care unit where there were additional staff as people's needs were higher. We reviewed the staffing rota for the month before our inspection and this tallied with what we had been told. Our observations of the number of staff on duty during our inspection also tallied with the rota and was sufficient to meet people's needs.

People were moved and repositioned in accordance with their care plan. People's care records contained a separate section entitled 'moving around'. This contained a care plan which included various sections such as how people liked to be moved, what their care needs were in relation to moving and repositioning, for example whether they needed any equipment to move around the building as well as what the person was able to do for themselves. The plan then contained detailed instructions for care staff about how to move people. For example, if people were required the use of a specific hoist, this was specified in the care plan and included the number of care staff required to move them and instructions about how to do this.

We observed care staff moving and repositioning one person using a hoist. We saw that the person appeared comfortable throughout the process and care staff communicated with them whilst moving them ensuring they were comfortable and safe. We spoke with care staff about how they used hoists to move people. All care staff were clear about the procedures they were required to follow when moving specific people, what type of hoist different people used and how many staff were required to move them.

We saw records showing that staff had received training in moving and repositioning people within the last year and care workers confirmed this. The training included discussions, watching videos and using equipment to practise their techniques in moving people safely.

Although we found that concerns had been addressed, work was still in progress and sufficient time had not passed to assure us that these improvements could be sustained. Therefore we have been unable to change the rating for this key question. A further inspection will be planned to check if improvements have been sustained.