Mr & Mrs J P Phillips

The Hollies

Inspection Report

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Ratings

Are services safe?

Contents

Overall summary

After our inspection of 16 and 17 April 2014 the provider wrote to us to say what they would do to meet legal requirements for the breaches we found. We undertook this unannounced focused inspection to check that the breaches of legal requirements had been addressed.

These breaches related to the safe management of medicines and the appropriate and effective assessment of risk to people's safety.

We undertook this focused inspection on 8 April 2015 to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Hollies on our website at www.cqc.org.uk.

The Hollies provides care and support for up to 19 older people some of whom have 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

Summary of findings

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 that the provider had addressed one of these breaches of legal requirements. However, we found a continued breach in relation to the safe management of medicines.

We found that people were not always getting the medicines they needed and staff were sometimes making mistakes when recording the administration of medicines.

The registered manager and provider had set up a system for checking the medicine records for everyone at the home however; this audit had not identified some errors that had been made.

The staff at the home, who had been given responsibility to administer medicines, did not have up to date training in the safe management of medicines.

This was in breach of Regulation 13 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments had been completed for all people who used wheelchairs, and footplates were being used for most people. Where a person did not want to have footplates attached to their wheelchair the risks and benefits had been discussed with them and this had been recorded and was being regularly reviewed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

The service was not safe because the recording of the administration of medicines was not always accurate and the system for auditing the management of medicines was not always effective.

Staff had not received up to date training in the management of medicines.

Risk assessments had been completed for all people who used wheelchairs and footplates were being used for most people. Where a person did not want to have footplates attached to their wheelchair the risks and benefits had been discussed with them and had been recorded and this was being regularly reviewed.

The Hollies

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.

We undertook an unannounced focused inspection of The Hollies on 8 April 2015. This inspection was undertaken to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 16 and 17 April 2014 had been made.

We inspected the service against one of the five questions we ask about services because the service was not meeting some legal requirements in this area.

During the course of the inspection we looked at four people's care plans and related risk assessments, the medicine administration records of six people, and the monthly medicine audit records dated January 2015, February 2015 and March 2015.

We looked at the most recent staff training matrix and staff training certificates. We spoke with the registered manager, the registered provider, two staff, three people who used the service and two relatives.

We checked the provider's action plan which they sent to us following the inspection we undertook in April 2014.

Are services safe?

Our findings

At the last comprehensive inspection on 16 and 17 April 2014, we asked the provider to take action to make improvements to the safe management of medicines. This was because we found errors in the administration of medicines to people who used the service. We also found that controlled drugs were not being stored appropriately.

As a result the provider sent us an action plan stating that they would be compliant with this requirement by May 2014. At this inspection we found that controlled drugs were now being stored appropriately and safely. However, we found that there were still serious errors in the administration of medicines to people.

We checked the medicine administration record (MAR) for one person which recorded the administration of medicines to that person from 10/03/2015 to 06/04/2015. This record included a weekly transdermal patch which is a controlled drug and prescribed for pain relief. The MAR had been signed by staff who recorded the patch as being administered weekly and there were four signatures in a four week MAR.

However when we checked the MAR with the stock of the transdermal patch, we found that two of these patches, which had been recorded as being given, where still in the controlled drug cupboard. This also meant that the stock balance of this controlled drug was inaccurate.

We discussed this with the registered manager and asked for an explanation. The registered manager concluded that, from the evidence we had seen, on two occasions in four weeks this medicine had not been given to the person despite being signed as being administered. This meant that for two weeks the person did not get the medicine prescribed for them for the relief of pain.

The registered manager and provider suggested to us that this may be due to the person not requiring this medicine. However, if this was the case staff should have signed the MAR as "refused" rather than record their signature which indicated the medicine had been administered.

The provider's action plan included the introduction of a medicine audit that would be completed on a fortnightly basis. At this inspection we looked at the medicine audits which were now being completed monthly. In the most recent audit, which covered the dates of the person's MAR, we saw that the audit had included the transdermal patch.

However the record of this audit showed this medicine as "correct." This means that the audit did not effectively identify the discrepancy with this medicine.

The action plan also stated that relevant training would be provided and or disciplinary action would be taken as a result of medicine errors. We looked at the most recent staff training matrix dated 17 February 2015. The last training recorded for the safe handling of medicines was November 2012 which three staff attended. Six other staff, who the registered manager told us were responsible for administering medicines, had not undertaken any up to date medicine training.

The registered provider and registered manager acknowledged that staff training in the safe management of medicines was required.

We saw that on each of the three monthly audits we checked, errors had been identified. The registered manager told us that she had undertaken observed competencies with individual staff who had been identified to have made mistakes in the administration and recording of medicines.

However, there were no records of this and the registered manager confirmed that she had not recorded these observed competencies. This means that there was no way of knowing if these observed competencies were effective in reducing the incidences of medicine errors. This means that the service continued to be in breach of the regulation relating to the safe management of medicines.

This was in breach of Regulation 13 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last comprehensive inspection on 16 and 17 April 2014, we asked the provider to take action to make improvements to people's assessment of risk in relation to using wheelchairs. This action has been completed.

Are services safe?

At the last inspection we saw that people who used wheelchairs to mobilise were not being provided with footplates which meant their legs were not being appropriately supported and therefore increased their risk of injury.

At this inspection we saw that footrests had now been fitted to people's wheelchairs. We noted that one person did not want to have footrests fitted to their wheelchair and we saw written evidence that the potential risk had been discussed with them and this was recorded in their care plan.

The person confirmed with us that they did not want a footrest on their wheelchair and that they had talked through this with the registered manager. The registered manager had assessed this person's capacity to make decisions and was aware that people had the right to make risky decisions as long as they had capacity to do so as described under the Mental Capacity Act (MCA 2005).

We saw that the use of footrests on wheelchairs was now being recorded in the section of people's mobility risk assessment where this was relevant.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had failed to ensure the consistent, proper and safe management of medicines at the service. This was because systems for monitoring and auditing medicines were not always effective and the registered person had failed to ensure that persons providing care or treatment in relation to medicines to people had the qualifications, competence, skills and experience to do so safely. **Regulation 12(1)(2)(c)(g)**