

Afra Siyab

# St Georges Residential 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

This inspection took place on 3 March 2016 and was unannounced. At the last inspection on 23 October 2015 we found the service was breaching the regulation relating to medicines management. This was because when we checked medicines stocks we were unable to confirm people always received their medicines as indicated on the Medicines Administration Record (MAR). After the inspection the manager wrote to us with their action plan setting out how they would improve medicines management.

The service provides personal care and support to people within a small care home setting. It specialises in providing care to people who have a learning disability and a range of communication needs. There were three people using the service at the time of our inspection.

There was no registered manager in post because the service was owned by an individual who was also the manager of the service. 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.

During this inspection we found that the manager had not sufficiently improved medicines management. This was because the service was repackaging people's medicines in pill dispensing boxes which is classed as 'double dispensing'. Double dispensing introduces a risk as only specific professionals such as pharmacists and chemists are able to dispense medicines as they have been specially trained to do so. Other staff administering the medicines cannot also be sure people are receiving the right dose of medicine at the right time, as prescribed, because they do not have the medicines original packaging with pharmacy label to double check as they administer to people.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The provider had not made all the required improvements to manage people's medicines safely. The staff were repackaging people's medicines in pill dispensing boxes weekly for the whole week which is classed as 'double dispensing'. Double dispensing introduces a risk as other staff administering the medicines cannot be sure people are receiving the right dose of medicines at the right time, as prescribed, because they do not have the medicines original packaging with pharmacy label to double check as they administer to people.

**Requires Improvement** ●

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## **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.

This inspection took place on 3 March 2016 and was unannounced. It was carried out by a single inspector.

Before our inspection, we reviewed the information we held about the service.

During our inspection we spoke with the manager. All people using the service and staff were out of the home doing various activities. We looked at records relating to medicines management in the service.

## Is the service safe?

### Our findings

At the last inspection we found the provider was not meeting the regulation relating to medicines management. This was because when we checked stocks for medicines we were unable to confirm people received their medicines as indicated on the Medicines Administration Record (MAR) as there were more medicines in stock than expected. After the inspection the manager wrote to us with their action plan setting out how they would improve medicines management. They told us they would introduce daily and weekly audits of medicines and would also request the pharmacist provide blister packs to minimise errors in administering medicines.

During the inspection the manager explained they had made alternative changes to medicines management to their action plan. They explained the pharmacist had refused to package people's medicines in blister packs. So each week care home staff or the manager packaged the medicines into pill organiser boxes themselves for the whole week. This is classed as 'double dispensing'. Double dispensing introduces a risk as only professionals, such as pharmacists, who have been specially trained are allowed to dispense medicines. It also means that other staff administering the medicines cannot be sure people are receiving the right dose of medicines at the right time, as prescribed because they cannot check medicines original packaging with the pharmacy label as they administer medicines to people. The Royal Pharmaceutical Society of Great Britain in its guidance 'The handling of medicines in social care' makes clear (pg. 54) that "Repackaging of medicines by care workers should not take place in care homes. The risk of making a mistake is too great." When we raised our concerns with the manager they told us they would stop this practice immediately. They told us they would look again to their pharmacist to package people's medicines in blister packs or make other arrangements to ensure people's medicines were dispensed appropriately.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

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 did not provide care in a safe way for people by ensuring the proper and safe management of medicines. Regulation 12(1)(2)(g)