North Yorkshire County Council

Benkhill Lodge

Inspection report

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Ratings

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 14 December 2015. A breach of legal requirements was found relating to the safe administration of medicines. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach.

We undertook this unannounced focused inspection on 15 December 2016, 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 (location's name) on our website at www.cqc.org.uk

Benkhill Lodge is registered to provide personal care for up to 30 older people. At the time of our inspection the service was providing care to 19 people on a permanent basis and three people on a temporary basis.

The service had a 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 this inspection we found that improvements had been made to the way staff administered medicines and this was now done safely. Staff had received additional training and competency checks took place to ensure staff administered medicines safely.

Medicines were stored safely and records relating to oral medicines and controlled drugs indicated that these had been administered in accordance with prescribing instructions. Records relating to creams were generally up to date, although we found one example where recording was inconsistent.

Records and checks were in place to support staff in the monitoring and ordering of medicine stock. This helped to ensure that medicines were available when people needed them.

Clear information was available to support the safe use of medicines used when required and topical medicines [medicines applied externally, such as creams].

Systems were in place to help ensure that people received their medicines when they needed them, including time specific medicines. Safe processes were in place to monitor the safe use of warfarin, to help ensure people always received the correct prescribed dose.

Audits and checks took place to ensure that medicines were being managed safely. This included responding appropriately to any 'near misses' or errors, to ensure that people were kept safe and the risks of reoccurrence were minimised.

The provider had a policy for medicine administration. This was in the process of being reviewed to ensure that it was up to date and reflected best practice guidelines.

Overall we found that improvements had been made and the service was no longer in breach of regulation.

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.

Staff had been trained on the safe administration of medicines and had their competency checked regularly.

Medicines were stored safely. Safe systems for stock monitoring, ordering and disposal were in place.

Oral medicines and controlled drugs were administered safely and in accordance with prescribing instructions.

The provider was in the process of reviewing and updating their medicine policies and procedures, to ensure they were safe and up to date with best practice guidance.

Benkhill Lodge

Detailed findings

Background to this inspection

We undertook this unannounced focused inspection of Benkhill Lodge on 15 December 2016. The inspection was undertaken by an adult social care inspector.

This inspection was done to check that improvements planned by the provider to meet legal requirements after our 14 December 2015 inspection had been made. The team inspected the service against one of the five questions we ask about services: Is the service safe? This was because the service was not meeting some legal requirements at our previous inspection.

Before our inspection we reviewed the information we held about the service. We reviewed the provider's action plan and information they had provided to us following our last inspection. We also reviewed any notifications and safeguarding alerts we had received. A statutory notification is information about important events which the service is required to send to the Commission by law.

During our inspection we looked at the arrangements for the management of medicines. We spoke with the registered manager and a senior care worker, who was in charge of medicines during our visit. We observed medicine administration and looked at how medicines were stored. We looked at records relating to four people's care and carried out checks on their medicines. We also looked at medicine administration and management records, staff training and support records, and audits.

Good

Is the service safe?

Our findings

At our last comprehensive inspection on 14 December 2015 we identified a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Safe care and treatment. This related to observations that members of staff had not administered medicines in a safe way, increasing the risk of errors or omissions occurring. Following the inspection the provider submitted an action plan telling us what they would do to put this right.

We spoke with the manager regarding the improvements made since our last inspection. There had been a review of everyone's prescribed medicines, undertaken by the local GP and a Clinical Commissioning Group pharmacist. This had helped to reduce amount of medicines people took and optimise their effect. Senior staff who were responsible for medicine administration had undertaken additional training and their competency observations had been updated to ensure they were administering medicines safely. There were also new systems for ordering and checking medicines in and out of Benkhill Lodge. The manager told us, "There are lots more checks in place regarding what (medicines) we are holding and who they are for."

We observed staff undertake medicine administration. We saw that improvements had been made to address the issues we identified at the last inspection. The staff we observed followed safe practices and treated people respectfully. People were given the explanations and time that they needed. This helped people decide if they wanted to take their medicines and take their medicines in a relaxed, comfortable way.

Since our last inspection staff had completed training on the safe administration of medicines and had their competency checked, using observations of their practice. We saw records confirming this.

We found that medicines were stored safely, with a refrigerator available for medicines needing cool storage. Fridge temperature monitoring ensured medicines were stored within the recommended temperature ranges. Arrangements were also in place for the safe storage and recording of controlled drugs. Controlled drugs are medicines that require increased monitoring due the risk of their misuse. The medicine storage facilities were clean, tidy and well organised. We also saw that medicine stock was carefully monitored and checked regularly, to ensure that people's medicines were available and re-ordered appropriately.

We checked a sample of medicine administration records [MARs] against medicine stock and found that these were correct. This showed that the medicines we checked had been administered in accordance with prescribing instructions.

We saw that arrangements were in place to ensure that people got their medicines at the right time. For example, some medicines needed to be given at specific times, to ensure people's wellbeing and comfort. The staff member we observed was able to tell us about these medicines and how they ensured people received them at the correct times.

Staff were able to show us the systems that were in place to ensure the safe administration of warfarin.

Warfarin is a medicine that requires careful monitoring to ensure the correct dose is always administered. We looked at the records relating to one person's warfarin and found that safe systems were in place to ensure that their records were up to date and reflected the most recent prescription instructions. This included working closely with other health professionals to ensure that information was communicated safely and promptly.

We found that where medicines were prescribed 'only when needed,' information to inform staff about when these medicines should and should not be given was available. This information helped to ensure that people were given their medicines in a safe and consistent way.

One person whose records we looked at was prescribed medicine administered through a transdermal patch. This meant the medicine was applied to their skin and absorbed over time. Staff were able to describe how they rotated the application site of the patch, but there was currently no formal process to record and monitor this. It is important to ensure that the application site of transdermal patches is rotated to prevent unnecessary side effects. When we discussed this with the manager it became apparent that they were aware of this issue. They assured us that the provider's revised medicine administration procedure [due to be implemented shortly] included the safe administration of transdermal patches and body map records for monitoring their application.

All care staff were responsible for administering and recording the use of prescribed creams and other topical applications [medicines applied externally]. These medicines and their administration records were kept in people's rooms for accessibility and ease of use. We looked at the records relating to the administration of four people's creams. Three of these records evidenced that the creams had been administered as prescribed, but one had unexplained gaps and did not evidence that the medicine had always been administered in accordance with the person's prescription. We discussed this with the manager, who acknowledged our findings and agreed to undertake additional training and support sessions with staff, focusing on the administration and recording of topical applications.

We saw records of a range of checks and audits that had been completed to monitor medicines administration and management. These had been completed by a range of different staff, including the manager, deputy manager and senior care staff.

Discussions with staff and review of records found no evidence of any serious medicine errors which had resulted in harm to people using the service. However, there had been three 'near misses' or omissions since our last inspection. These had been recorded and investigated, with records showing the actions taken by staff to ensure people were kept safe. For example, staff had obtained prompt medical advice and support. The manager had also reviewed these incidents, undertaking further preventative actions where necessary. For example, they had implemented additional staff training/support sessions and reviewed systems. This helped to ensure that staff learned from incidents and the risk of reoccurrence was minimised.

The provider had a policy for medicine administration. This was in the process of being reviewed to ensure that it was up to date and reflected best practice guidelines.