Eastleigh Care Homes - East Street Limited

Eastleigh Care Homes

Inspection report

90-91 East Street
South Molton
Devon
EX36 3DF
Tel: 01769572646

Date of inspection visit: 14 January 2016
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Ratings

Is the service safe?	Good

Overall summary

This was a focussed inspection to look at handling of medicines in the home. This followed the service notifying the Care Quality Commission (CQC) of two incidents, which resulted in people not receiving their medicines as prescribed for them. In both incidents, staff identified their mistakes quickly and took appropriate action to make sure the people involved did not come to harm. When we last inspected in March 2015 we did not find breaches in the way medicines were being managed, but in light of the notifications in relation to medicine errors occurring, we decided to inspect this area.

Two pharmacist inspectors completed this unannounced inspection on 14 January 2016.

We found that safe systems were in place for handling medicines. People told us they got their medicines when they needed them.

Medicines were stored safely and securely. Staff had received appropriate training to enable them to administer medicines safely and effectively.

Records in relation to medicine management were accurate and up to date and systems were in place to audit the process. Extern audits were also arranged via the local pharmacy.

This report only covers our findings in relation to medicines. 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

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?

Medicine management was safe.

Systems were in place to ensure safe storage, administering and recording of people's medicines.

Good

Eastleigh Care Homes

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.

Before our inspection, we reviewed the information we held about the home, which included incident notifications they had sent us. A notification is information about important events which the service is required to tell us about by law.

During this inspection we spoke with three people and with six staff members. We looked at five records in relation to people's medicines and we observed medicines being administered for people over the lunch period.

Good

Is the service safe?

Our findings

This was a focussed inspection to look at handling of medicines in the home. This followed the service notifying the Care Quality Commission (CQC) of two incidents, which resulted in people not receiving their medicines as prescribed for them. In both incidents, staff identified their mistakes quickly and took appropriate action to make sure the people involved did not come to harm.

We found that safe systems were in place for handling medicines. Staff told us people were able to look after their own medicines if they wished to and could do so safely. At the time of our inspection, staff administered all the medicines used in the home.

Staff used an electronic system to record the receipt, administration and disposal of medicines. Senior care staff gave people their medicines. We saw staff give four people their morning medicines and two people their lunchtime medicines. Staff used safe practice and recorded the medicines they had given.

We looked at five people's medicines administration records. Staff had recorded people had received their medicines as prescribed. Codes were available for staff to record the reason if they had not given a medicine. We looked at three packets of medicines and saw that the quantity in the pack confirmed the stock balance recorded on the screen. Staff told us the electronic system they used would highlight any medicines not given at the correct time. This helped to ensure people received their medicines correctly.

Some people were prescribed medicines to be given 'when required', such as those for pain relief or to treat anxiety. Additional information was available to help staff give these medicines in a safe and consistent way. The recording system also prompted staff to go back to the person after two hours, to check whether these medicines had been effective. Staff told us they were able to look back over time to see how often people had needed 'when required' medicines. They could then advise healthcare professionals about their use and effectiveness. This helped ensure people had safe and effective treatment.

Creams and ointments were kept in people's rooms and applied by care staff who provided personal care. At the time of the inspection, staff recorded the application of these products on paper records. These records did not always show whether staff had applied these preparations. Staff told us they had recognised that this was a problem. To improve this they had taken action towards care staff using the electronic system to record application of creams and ointments.

Staff told us that all the senior care staff had training so they could use the medicines system correctly. They did not use agency staff so people could be assured staff would know how to safely us the system. Following the medicines errors staff had further training to remind them of the importance of following the appropriate procedures. This helped to reduce the risk of mistakes being made in future.

Policies and procedures were in place for safe handling of medicine. Some policies were not available because staff were reviewing them. They planned to have them in place by the end of the month, following consultation with nursing staff from a sister home.

Medicines were stored safely and securely. Staff used locked medicines trolleys to transport medicines in the home. A medicines refrigerator was available. Staff recorded the daily temperature to make sure this was in the safe range for storing medicines. Suitable storage was available for controlled drugs, which need additional security because of the risk of their abuse. Staff checked these medicines frequently. Records showed these medicines were looked after safely.

Staff had arranged for the community pharmacy team to visit the home and check their systems for handling medicines. The team arrived during our inspection and said they would return later. The manager told us of the checks she was able to do, taking information from their electronic system. We saw the result of a quarterly medicines audit, dated September 2015, that had not identified any significant issues. Staff told us they checked the administration records on a monthly basis. This allowed them to identify and investigate any discrepancies. We saw an example of this from November 2015. This helped to ensure staff managed people's medicines safely.