Tracs Limited

Highbridge Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was unannounced and took place on 01 August 2016. This was a focussed inspection to look at what improvements the home had made with regard to medicines administration since their last inspection. The last inspection of the home was carried out in January 2016 and the home was rated as requires improvement. Three breaches of regulations 12, 11and 17 of the Health and Social Care Act 2008 were identified.

Highbridge Court is a care home providing accommodation for up to nine people with mental health needs. At the time of the inspection, four people were living there. Each person had a self-contained flat with their own cooking facilities, table and comfortable seating. Each flat has an en-suite shower room. There is a small communal area with a dining table and a sofa, and a communal kitchen area where staff prepare meals at the weekend.

There is a registered manager in post. 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.

Staff promoted people's privacy and dignity by asking people if they wanted to return to their rooms to have their medicines in private. We observed staff giving medicines to people and saw people consented to this.

Medicines were stored in a secure, locked room which was protected from heat and damp to ensure the medicines did not lose their effectiveness. Medicines waiting to be returned to the pharmacy were kept separately. Staff sent unused or wasted medicines back at the end of the month, so there were no excess stocks of medicines.

Staff did not record accurately when one person had received the correct number of medicines they should have, in one day. Although staff were counting medicines every day, the audits had not picked this up.

Staff did not record dates when creams were opened and when creams expired on the box, which meant there was a risk creams could be applied after they had expired. There was no written guidance for staff where to apply creams, or how much to apply.

Not all staff had undergone checks to ensure they were competent to give people their medicines as stated in the provider's policy. Of the five staff files we looked at, two staff did not have the required checks in place.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Medicines were not always managed safely.

Staff were trained to administer medicines. Two out of five staff we looked at did not have up to date checks to make sure they were competent to give people their medicines.

People knew what medicines they were taking and what they were for. Staff respected people's privacy and dignity whilst administering medicines.

People's medicines were ordered in a timely manner.

When one person did not receive their medicines, staff had not recorded the reason for this. Although staff completed daily checks on medicines to make sure they were safe, they had not picked this up.

Highbridge Court

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 1 August 2016 and was unannounced. It was carried out by one inspector. This was a focussed inspection to look at medicines administration; we did not complete a full inspection, therefore the rating awarded from the last inspection remains unchanged. At the last inspection on 29 January, 01 and 04 February 2016, Highbridge Court was breaching three regulations of the Health and Social Care Act 2008 and were rated as requires improvement.

Before the inspection, the provider did not complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not ask for a PIR because this was not a full, comprehensive inspection. We looked at information the provider sent us in the form of notifications and also looked at other information we held about the home before the inspection visit.

We spoke with two members of staff and the registered manager. We also spoke with one person who uses the service. We looked at medicine administration records for three people and documents relating to the management of medicines, such as staff training records and competency to administer medicines for five members of staff. We looked in the medicines room and checked the storage facilities.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection on 29 January and 01 February, we found medicines were not well managed. The amount of medicine recorded was not always the same as the actual medicine in stock. Daily checks and weekly stock checks had not all been completed. Medicine identification sheets did not identify the person. Some medicines had been stored at temperatures above those recommended. A key performance audit had not identified if staff competency observations were overdue or whether the records were missing. There was no record to show a medicine had been delivered to a new location. We found some improvements during this inspection, but some concerns remained.

Staff told us a new process where staff could do medicines training online had been developed, which was supposed to start on the day of the inspection. Staff said the new process would identify when they were due to be observed for competency regarding medicines needed to be checked. Competencies are the set of skills staff need to be able to undertake their role safely. The registered manager told us staff should have five competency checks every six months. We looked at five staff files to check staff competencies had been checked. One file only had three competency checks and one file had records of competency checks which were all out of date. This meant the member of staff had not been observed for over six months, as was required in the provider's policy. The registered manager assured us they would complete the competency checks as soon as possible. Staff said they would be re-doing the online training every two years, this covered general requirements for giving medicines. Staff said they would also have clinical training annually, which was more in-depth training about specific medicines people took. We asked to see the training records which showed staff had completed the required medicines training. The registered manager was unable to locate this information at the time, but supplied the information about staff training the day after the inspection.

We checked the actual number of medicines in stock were the same as the numbers listed on the medicine administration record (MAR). We found one instance when the numbers showed one person had not received the full number of medicines they should have, in one day. We discussed this with the member of staff, who later remembered the pharmacy had been late supplying the medicine, as the order was a new prescription. The person was supposed to have this medicine four times daily, but due to the late arrival of the medicines they had only had three doses one day. This had not caused harm to the person, but when staff do not record accurately there is a risk vital information may be missing for example when a GP reviews the person's medicines. The audits staff completed had not identified this error.

We saw one person used creams which they were able to self-administer. Another person had a cream which staff applied. The date the box containing the cream had been opened and the date the cream expired had not been written on the box. This meant there was a risk the cream could be used after the expiry date. There were no written records giving instructions for staff of how much cream should be applied or showing the area it needed to be applied too. This meant there was a risk the cream may be applied differently by different staff, and therefore the cream may not be as effective for the person. The registered manager sent us a copy of the blank records which were going to be provided for staff to use, the day after the inspection. Staff told us, "It's a small home with only four people; we know what the cream is

and where it needs to be applied." Staff recorded they had applied the cream on the MAR sheet. However, the lack of clear directions meant information was not available for new or agency staff, and the person may not be given the creams as directed by the prescribing GP.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

We saw medicine administration records (MAR) for each person. Identification sheets for each person had a photograph with the person's name and date of the photograph. This meant each person could be safely identified and reduced the risk of giving people the wrong medicine. The MAR sheets were legibly written and a clear list of staff names and initials was available. This meant it was possible to identify which member of staff had given medicines on any given date. The MAR sheets were checked twice daily, at each shift change. If staff had forgotten to sign them, they would be asked to return to the home to do so. Staff would also receive a one to one meeting to ensure they understood the importance of correctly completing these records. Staff told us there had not been any near misses or medicines errors. A near miss is something that has gone wrong before the medicine reached the person, so there was no actual harm. Staff told us if a medicine error did occur, they would phone NHS Direct for advice, observe the person and follow the procedures in the policy. This included telephoning the GP, the local authority safeguarding team and the registered manager or the deputy manager.

We looked at how medicines were managed when people were moved to the home. Staff told us the medicines were labelled and they phoned the person's previous home to check the medicines were correct. The person was registered with a local GP when they were moved so they had access to a local GP and to make getting regular prescriptions easier. When people went to stay with relatives, we saw a form was used which meant there were clear records of what medicines had been handed over when people left the home, and similarly, medicines were also checked when the person returned to the home. This meant there were clear records when medicines were brought in and left the home.

Staff promoted people's privacy and dignity by asking people if they wanted to return to their rooms to take their medicines in private. We observed staff giving medicines to people and saw people consented to this. The person we spoke with knew why they took their medicines and were able to tell us what they were for. One person was able to self-administer their medicines. Staff had risk assessed this and supported the person appropriately.

No-one needed medicines which required extra security and recording but these were in place if they were needed. Staff were aware of the requirements for keeping these medicines and the procedures for signing when they were administered.

There were practices in place for managing medication when it was refused by people. Staff told us if people refused their medicines, staff would ask the person every 15 minutes if they would take their medicines. If people continued to refuse to take their medicines after an hour had passed, the medicines would be put in the returns bag and locked away. The person's refusal would be documented in the medicine administration records and the returns book, and their daily notes would be updated. Staff told us they would inform the appropriate healthcare professionals about any refusals, so they would be aware if the person required any additional care or treatment as a result. Other staff would also be informed if people had refused their medicines during the handover meeting at the end of each shift, so they knew to watch the person for any signs they were deteriorating.

We checked to see if the medicines were stored in a locked room which was protected from heat and damp

to ensure they remained effective and they were. The room had recently had a vent added as there were no windows, and keeping medicines below 25 degrees had been challenging in hot weather. The shift leader kept the keys throughout the shift and handed them over to the next shift leader at the end of the shift. We checked the records of fridge temperatures and saw they were within the recommended ranges. One person had their own medicines fridge in their own room; we saw the temperatures of this fridge were within the recommended ranges as well. The home used blister packs as produced by the pharmacy. This meant people's medicines were stored individually. Medicines designed for internal and external use were kept separately. This meant medicines were stored safely, which reduced the likelihood of medicines errors.

Where people required medicines on an as needed basis, such as paracetamol, a prescription was obtained and the medicines therefore showed on the MAR sheet. Staff told us if people needed to take paracetamol regularly they would ask the G.P. to review the person's medicines. Where staff took verbal messages from healthcare professionals, staff told us they would ask for the information to be confirmed in an email and would document the message in the person's daily records. This information would also be shared with other staff during the handover meeting.

There were clear systems in place to ensure people's medicines were ordered regularly and in a timely manner. Two weeks were allowed between sending the prescriptions to the G.P. and receiving the medicines from the pharmacy. Two staff were responsible for signing medicines in when they were delivered to the home.

Lists of people's medicines were kept in the medicines room and alongside details of people's health checks. Staff told us people's medicines were reviewed every six months to one year, or sooner if there were any changes in the person's condition. Staff told us people were involved in these reviews where possible.

One staff member had been given responsibility for everything to do with medicines in the home, and other staff had also been trained to take over when this person was not available. This meant there was always a member of staff who was responsible for the management of medicines.

Medicines which needed to be returned to the pharmacy were stored securely in a separate container. A signature was obtained when the medicines were collected by the pharmacy and the returns paperwork was dated. Medicines waiting to be returned to the pharmacy were kept separately. Staff sent unused or wasted medicines back at the end of the month, so there were no excess stocks of medicines.

No-one needed to have their medicines given to them covertly at the time of our inspection. Staff were aware of the homes' policy for giving covert medicines and told us the decision to give someone covert medicines would be made at a best interest meeting. A best interest meeting is where healthcare professionals, staff and family will make decisions in the person's best interests. Staff were aware that putting some medicines into easily swallowed foods such as yoghurt could alter how the medicines worked.

The provider had an effective medicines audit system in place. The area manager completed a medicines audit in June 2016, and looked at the MAR sheets, the audits completed by staff and any medicine alerts raised. They noted there were no missed signatures on the MAR sheets and recent audits had been completed. The daily audits staff completed included checking records in the person's care plan had been completed, checking the MAR sheets had been signed and counting the medicines, checking people's identity sheets were in place and checking fridge and room temperatures had been taken and recorded. This meant action could be taken to correct any errors or omissions identified. The registered manager told us they did a daily audit of medicines; however there were no records to show this.

Information sheets were available to give staff details of any side effects of medicines. We asked if staff had access to other, well-known sources of advice such as the 'Managing Medicines in Care Homes 2014' guidance, however, they did not. The registered manager told us they were able to telephone a sister home if they needed any advice.

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 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 Medicines were not always managed safely.