Hoylake Cottage

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Inspection report

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Overall summary

The inspection took place on 27 October 2015 and was unannounced. Prior to the inspection we had been informed of a number concerns regarding the safe handling of medicines which were being investigated by the local authority.

The inspection was conducted by an inspector who is a pharmacist and only looked at how safely medicines were handled. We found that medicines were not being handled safely and found that they were in breach of **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Hoylake Cottage' 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?

Requires improvement

Hoylake Cottage

Detailed findings

Background to this inspection

During the inspection we spoke to the registered manager about medicines handling in general. We looked at how medicines were handled for eight people who were staying on the intermediate care unit and a further five people who were living in the second floor dementia unit. We also looked at records about all 13 people's medicines. We spoke with the nurses in change of administering medicines on both units and a care worker working on the dementia unit.

Requires improvement

Is the service safe?

Our findings

During the inspection we observed one nurse administering medication which she did in a friendly and unhurried way and people were given their medicines safely.

We saw that there were systems in place to make sure that people were given their medicines safely. We saw that when dose changes were made to people's medicines they were actioned safely and speedily. We saw that safe procedures were in place to make sure that people were given their medicines at the correct time with regard to food and to ensure there was a safe time interval between doses of analgesics such as Paracetamol.

The manager told us that new procedures had been put in place to ensure that when nurses made handwritten entries on the medication administration record sheets (MARS) that the information in that entry was accurate. However we saw that sometimes these procedures were not followed. We also found that some of the information needed to ensure medicines were given safely was missing or not recorded. This meant that people may not have been given their medicines safely.

On the day of our visit we saw that most medicines were stored safely, however we did see that sometimes creams were stored in people's bathrooms without a risk assessment to show it was safe to do so.

We checked the MARS against the actual stock of medicines for some people and found that, although most medication was administered as prescribed, there were some discrepancies. We saw that medicines had been given but not signed for and signed for but not given.

We found that when medicines were prescribed to be given 'when required' (PRN), there was no information available to guide nurses to help them make decisions if people needed that medication. There was no information available to guide staff which dose to give when there was a choice of dose. We also noted that there was little information available to guide staff as to where to apply prescribed creams. It is important this information is available to ensure medicines are given and creams are applied safely and consistently at all times.

We saw that there was a lack of written information available to guide staff making drinks for people who needed their fluids thickened. There were several people in the home with swallowing difficulties, who were prescribed a thickening substance to help them have drinks safely without the risk of choking. A member of staff told us they just remembered who needed to have thickener added and how thick it should be. It is not safe for the staff to rely on their memory in this way.

We saw that, although there was a good system in place for ordering medicines, one person had run out of one of their medicines which they only took once a week. Nurses could not explain why it had run out and they told us they would order it immediately.

Nurses recorded the time medicines such as Paracetamol were given so that the nurse giving the next dose could check that a safe time interval elapsed between doses. During the inspection we saw one of the nurses check this information and avoid giving a dose of Paracetamol too soon which was good practice. However, when we checked another MARS we found that one person had been given their Paracetamol doses too close together on three occasions.

We looked the records about medicines for people and we found that most of the MARS were completed well and they showed people were given most of their medicines safely. However, we found that there were a number of gaps, missing signatures, on the MARS where it was impossible to tell if medicines or creams had been given or not. There were no records made about the use of thickeners. When there was a choice of dose, staff did not always record the exact dose given to people When medicines were carried over to the following month or new medicines received, staff did not always accurately record the quantity in the home. This meant the medication could not be audited and accounted for.

We saw the use of codes on the MARS to explain why medicines had not been given were inconsistent and we found that sometimes staff signatures were unclear and it was difficult to tell if medication had been given.

We also saw that nurses signed the MARS to show they had applied creams which had been applied by care staff. It is important that records are competed accurately by the person applying the cream so that records about medicines are believable.

We saw that some people did not always want to take their medicines and the nurse told us they were given their

Requires improvement

Is the service safe?

medication covertly, by hiding medication in their food or drinks. We looked at the care files for two people who were given their medicines in this way. One person had no approval for medicines to be given in this way and the other person did not have the correct paperwork in place. A pharmacist had not been consulted to check how to give the medicines safely hidden in food or drink.

The manager told us that audits were done regularly and we saw two audits which had been carried out by the trustees in the middle of October 2015. We saw that the audits had picked up some concerns but there was no evidence recorded that these concerns had been addressed to prevent them reoccurring.

We were also told that nurses had not yet had medication training but there was a plan to deliver it in house soon.

The manager told us that only two of the ten nurses employed had completed competency assessments and she needed to do competency assessments for the other eight nurses.

It is important that nurses and staff administering medicines have up to date training on safe medicines handling and have robust competency assessments to ensure people's health is not placed at risk of harm.

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

At the end of the inspection we gave detailed feedback to the manager who was open and receptive to our findings and discussed ways the service could improve their safe handling of medicines.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not ensure the proper and safe management of medicines**