Mr & Mrs Murphy C Hampton and Ms C Hampton

Lakenham Residential Care Home

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

The inspection took place on 1 March 2016 and was unannounced.

Lakenham Residential Care Home is a care home which provides care and support to older people some of whom have been diagnosed with a form of dementia. The home does not provide nursing care. The home can accommodate up to 28 people.

The service is required to have 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. There was no registered manager in post but a new manager was recently appointed. They said they were starting their application to register with the Care Quality Commission.

Our previous inspection, September 2015, found that medicine management at Lakenham Residential Home, was not safe. We issued a warning notice. During this inspection, we found that improvements had been made to address the areas of concern in the warning notice.

Staff had taken action to improve the ordering system to reduce the risk of medicines being out of stock. Staff recorded the receipt of medicines into the home so it was possible to check that administration records were accurate. People we spoke to did not have any concerns about how staff looked after their medicines.

Medicines training had been provided for staff to help ensure staff followed safe practice.

Some further action was needed to make sure that people's medicines were looked after and given safely.

There was no additional information available to staff when people were prescribed medicines to be given 'when required', to help them give these medicines in a safe and consistent way.

There was no formal system to check that staff continued to give medicines safely. This increased the risk of unsafe practice continuing.

There were a continued breach of regulation. You can see what action we told the provider to take at the back of this report.

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

Improvements had been made to address the areas of concern with regard to medicine management but some further action was needed to make sure that people's medicines were looked after and given safely.

Lakenham Residential Care Home

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 follow up a warning notice, look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We carried out an unannounced, focussed inspection on 1 March 2016. This inspection team consisted of a pharmacist inspector and an adult social care inspector.

Before the inspection, we reviewed the previous inspection report, the warning notice and the action plan the provider had sent in response to this.

We spoke to three people living in Lakenham residential home, one person's visitor, two staff members, the newly appointed manager and one of the providers. We looked at seven people's care records relating to their medicines and the medicines administration records (MARS) in current use, and for the previous month, for all the people living in the home.

Requires Improvement

Is the service safe?

Our findings

During this inspection, we found that improvements had been made to address the areas of concern in the warning notice. However, some further action was needed to make sure that people's medicines were looked after and given safely.

Staff had taken action to improve the ordering system to reduce the risk of medicines being out of stock. People's medicines were available for them.

Staff recorded the medicines received into the home on people's medicines administration record (MAR) charts. We checked a sample of records with the supply of medicines. We found the medicines missing confirmed the administration records staff had made. This helped to demonstrate that staff had given people their medicines correctly.

The pharmacy provided printed MAR charts for staff to complete when they gave people their medicines. On some occasions staff had made handwritten additions to these charts. In most cases, a second member of staff had signed the record to show they had checked it, to reduce the risk of mistakes being made.

We saw two examples where staff could give people their medicines covertly. This means that staff can disguise the medicine in food or drink to make sure the person takes it. Safeguards were in place to make sure people were protected and received their medicines in a safe way.

People we spoke to did not have any concerns about how staff looked after their medicines. However we found that some further improvements were needed to ensure people's medicines were always looked after safely.

Some people were prescribed medicines to be given 'when required', for example for pain relief or to treat anxiety or agitation. Some of these medicines had a variable dose. Staff were able to describe when they gave these medicines and how they decided which dose to give. However, there was no written information for staff to help ensure that people received these medicines in a safe and consistent way.

Staff checked all the MAR charts every month to make sure people had received their medicines correctly. A process was in place for recording medicines errors. New staff had a competency assessment and were supervised to make sure they were safe to give people medicines. All staff involved with giving people their medicines had attended medicines training recently. However there was no formal system to check that staff continued to give medicines safely, even after a medicines error had occurred. This increased the risk of unsafe practice continuing.

This did not follow current national guidance for the safe administration of medicines in care homes.

This was a breach of Regulation 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

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 There was no written information for staff to help ensure that people received prn and variable does meds these medicines in a safe and consistent way. There was no formal system to check that staff continued to give medicines safely, even after a medicines error had occurred. This did not follow current national guidance for the safe administration of medicines in care homes. Breach of Reg 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regs 2014 (Part 3)