Care UK Community Partnerships Ltd

Honeysuckle House

Inspection report

1a Oakthorpe Road
Palmers Green
London
N13 5HY

Tel: 02088868086
Website: www.honeysucklehousepalmersgreen.co.uk

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Ratings

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

Summary of findings

Overall summary

At our last inspection of this service on 16 October 2014, the provider was in breach of the regulation relating to medicines management, Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). The provider sent us an action plan after the inspection detailing how they would meet this standard. At this inspection we found that improvements had been made, medicines were being managed safely and the provider was no longer in breach of this regulation.

This inspection took place on 30 March 2016 and was unannounced. This inspection was carried out by a single pharmacist inspector. This report only covers our findings in relation to the safe management of medicines within the safe section. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Honeysuckle House on our website at www.cqc.org.uk .

Honeysuckle House provides accommodation for up to 32 older people some of whom are living with dementia. There were 31 people living at the home on the day of our inspection.

There was a registered manager in post but they were away on leave on the day of the inspection. 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 and associated Regulations about how the service is run.

We were assisted during our inspection by the deputy manager.

All of the issues we found with medicines at the last inspection had been addressed. Medicines were stored safely, and there were no omissions in recording on people's medicines administration records. All staff administering medicines had been assessed by the provider as competent to do so. On the day of our inspection, we fed back three minor areas for improvement with medicines relating to recording medicine refusals, pain management reviews and the covert administration of medicines.

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. The provider had made the necessary improvements relating to the safe management of medicines.

Honeysuckle House

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 checked 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.

We undertook an unannounced focused inspection of Honeysuckle House on 30 March 2016. This inspection was undertaken to check that improvements to meet legal requirements planned by the provider after our last inspection on 16 October 2014 had been made.

We inspected the service against one of the five questions we ask about services: is the service safe. This is because the service was not meeting some legal requirements. The inspection was carried out by a single pharmacist inspector.

Prior to the inspection we checked the action plan that the provider sent us following the inspection in October 2014. We also looked at notifications the provider had sent us that are required by law under the Health and Social Care Act 2008. During the inspection we looked in detail at records relating to the safe management of medicines at the home, records related to medicines training, and how medicines were stored.

Good

Is the service safe?

Our findings

At our last inspection of the service on 16 October 2014, we found that the provider was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) relating to medicines management.

Medicines were not always stored safely. There were discrepancies between the list of staff assessed to give medicines, and those staff actually administering medicines to people. There were repeated omissions in the recording of medicines administered to people, which were attributed to a bank member of staff who was not on the list of staff assessed as competent to administer medicines.

The provider sent us an improvement plan, setting out how they would address the breach.

At this inspection we found that all of the issues relating to the safe management of medicines we reported on our last inspection had been rectified.

Medicines were stored safely in the two medicines rooms at the service. These rooms were clean, organised and kept locked when not in use. The deputy manager told us that the medicines room keys were always kept with the nurse in charge and were not left unattended or with unauthorised staff. All of the cupboards within the rooms which contained medicines were also locked. There was a separate controlled drugs cupboard. This was secure, however we asked the deputy manager to check with their pharmacist whether the construction of the cupboard complied with the legal requirements of the Misuse of Drugs (Safe Custody) Regulations.

We checked the stocks of controlled drugs against the balances in the controlled drugs register, and these tallied. For a controlled drug pain-relieving patch, a patch application record was in use, recording the site of application of the patch, and evidencing that the patch site was being rotated to reduce the risk of side effects. As there was only one nurse on duty on some shifts, we saw from the CD register that the deputy manager or the nurse from another floor witnessed the administration of controlled drugs. The deputy manager confirmed to us that staff left the floor to witness the administration, and did not just check the entry in the register.

We checked medicines administration records for people living at the service and saw that these were completed clearly and in full. These records showed that medicines were available, and people were receiving their medicines as prescribed. There were no gaps in the recording of administration on any records. Each person had a resident profile, which listed any allergies, how people preferred to take their medicines, and a photograph to aid identification. The date of the photograph was recorded, so we were able to check that these photographs were recent.

There were safe arrangements in place for the administration of a high-risk medicine, insulin. A body map was in place, to record the injection site and the date and time of the injection, which was witnessed by

another member of staff.

Patch application records were in place for two medicines prescribed as a topical patch, Buprenorphine and Rivastigmine, to record the site of application, and evidence the rotation of the patch site to reduce the risk of side effects. Topical medicines application records were in use to record the application of prescribed creams.

Protocols were in place for almost all medicines prescribed to be given as needed or "PRN". There was information for staff on whether someone was able to request their PRN medicine or whether staff had to carry out an assessment to determine whether to administer a dose. We highlighted a few medicines for which PRN protocols were not available on the day of our inspection, and we were assured that these would be put in place immediately.

Staff responsible for administering medicines had received medicines training and there were formal documented assessments of their competency to administer medicines. The deputy manager told us that the service did not need to employ agency staff to administer medicines during the day, but occasionally employed agency staff to administer medicines on night shifts. There was an induction pack for agency staff, which permanent staff went through with agency staff before they began their shift, and this induction pack included an overview of the provider's medicines policy.

Four people who had regularly refused essential medicines in the past were receiving their medicines covertly, and this was being done in accordance with the Mental Capacity Act (MCA 2005). Mental capacity assessments and best interests decision records were in place for people that lacked capacity to understand their medical needs. The GP had given authorisation for these medicines to be administered covertly. There was written evidence that the pharmacist had provided advice about the method of covert administration to ensure it was carried out safely. They had advised the home not to crush one medicine, bisacodyl, and to request a soluble version of another medicine, paracetamol.

We noted some minor areas for improvement, which had not been an issue at our last inspection.

Four people were refusing some doses of their medicines, and staff had not made a record on the back of their medicines record to document any action taken, such as whether the GP had been informed, although the deputy manager confirmed to us that the GP had been made aware of this.

For people prescribed pain relief, pain-rating scales were in use, to assess people's level of pain, and to help staff make a decision on whether people's pain was being managed adequately. This was particularly useful for people living with dementia, who were unable to communicate their pain well. We noted that these were not always used when needed, for example for one person, the last time the pain rating scale had been used was on 3 February 2016.

Although the four people receiving their medicines covertly did not have any allergies to medicines, the same tablet crusher was being used, and washed between each use. We advised that it would be safer to obtain separate tablet crushers to prevent cross-contamination, especially if staff needed to crush tablets in the future for anyone with allergies to medicines.