

Devonshire House Care Limited Devonshire House

Inspection report

The Green West Auckland Bishop Auckland County Durham DL14 9HW Date of inspection visit: 26 August 2016

Date of publication: 16 September 2016

Tel: 01388833795

Ratings

Overall rating for this service

Is the service safe?

Good

Good

Summary of findings

Overall summary

This inspection visit took place on the 26 August 2016. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting. This was a follow up visit to look at issues we found on our visit to Devonshire House on 15 January 2016.

We had visited the service on the 15 January 2016. We had found that medicines were not stored and administered in a consistently safe manner. There was a risk that people were not receiving their medicines as prescribed due to poor record keeping. We issued a requirement notice to the registered manager to send us a report (action plan), within 28 days, on how they intended to mitigate and address the breach of Regulation 12 of the Health and Social Care Act 2014 in managing medicines safely. The registered manager sent this report to us promptly and we were satisfied with how they intended to address the issues we found.

Devonshire House is situated in the village of West Auckland close to all amenities. It currently provides residential and respite care, nursing care and care for people with dementia and people with physical disabilities. There are 21 single occupancy rooms and 2 double occupancy rooms. Three of the rooms within the home have en-suite facilities. The service is family owned and it has a close knit, family feel to the home.

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. The registered manager was a registered nurse and had worked at the home before they applied to be the registered manager.

On this visit we were met with a registered nurse who showed us how medicines were stored, dispensed, ordered and returned. They explained the checks they carried out to ensure medicines were administered correctly. They also showed us the new policies the service had written which staff had read and signed. This nurse told us the service had reviewed how it dealt with medicines and had discussed this in meetings and in supervision sessions with the registered manager.

We saw medicines were stored and administered safely.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

We saw that medicines were stored and administered in a safe manner.





Devonshire House

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 (HCSA) and to review a breach of Regulation 12 in relation to medicines that we found on our visit to the home on 15 January 2016.

This inspection took place on 26 August 2016 and was unannounced.

The membership of the inspection team was one adult social care inspector.

We reviewed all of the information we held about the service including statutory notifications we had received from the service. Notifications are changes, events or incidents that the provider is legally obliged to send us.

At our visit to the service we spoke with the registered nurse in charge at the time of our visit and spoke with the registered manager on the telephone following our visit. We looked at the medicine administration records for eight people who used the service and we reviewed policies and other records in relation to medicines.

Our findings

We had visited the service on the 15 January 2016. We had found that medicines were not stored and administered in a consistently safe manner. There was a risk that people were not receiving their medicines as prescribed due to poor record keeping. We issued a requirement notice to the registered manager to send us a report (action plan), within 28 days, on how they intended to mitigate and address the breach in managing medicines safely. The registered manager sent this report to us promptly and we were satisfied with how they intended to address the issues we found.

On this unannounced visit we were met by the registered nurse in charge of the home. They showed us the medicines and we saw the medicines trolley was clean and very tidy. Medicines were kept securely in locked cupboards. The medicines room was also clean, free from clutter and medicines were stored at the correct temperatures with records of this maintained.

We looked at the medication administration records (MAR) for eight people. Clear records were kept to show when people had their medicines. People who used the service had their medicines at the times that they needed them and in a safe way. All medicines were available for administration as prescribed.

We saw the registered manager had carried out discussions via meetings and recorded supervision with all registered nurses at the service to discuss the safe administration of medicines. The nurse we met with told us this had been helpful to review their policies, systems and knowledge.

We saw the registered manager had reviewed and updated their medication policies in accordance with National Institute for Health and care Excellence (NICE) guidelines and the Nursing and Midwifery Council (NMC). We saw that the nursing team had signed to acknowledge they had read these revised policies.

The registered manager had developed a new monthly medication audit in accordance with NICE guidelines. We saw that the staff completed regular audits of the medicine administration records and took action to resolve any discrepancies. There was also a weekly stock check of all medication which included controlled drugs. Controlled drugs are drugs which are liable to misuse and as such have stricter guidelines for storage, administration and disposal. We saw written guidance kept with the medicines administration records (MAR) charts, for the use of "when required" (PRN) medicines, and when and how these medicines should be administered to people who needed them, such as for pain relief.

There was evidence of topical medicines application records to show the topical preparations people were prescribed, including the instructions for use, the associated body maps and the expiry date information.

The registered manager told us they had been working more closely with the pharmacy and had made changes to improve the way the home worked with the pharmacy and GP practices locally.