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St James House

Inspection report

St James' Crescent
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Ratings

Overall rating for this service	Good
Is the service safe?	**Requires improvement**

Overall summary

This was an unannounced inspection which took place on 20 October 2015. The service was last inspected on 15 June 2015 when we undertook a focused inspection to see if the provider had taken action against a requirement notice that had been issued. This was because people were not protected from the risks associated with the unsafe management of medicines. We found the required improvements had not been made and issued the provider with a warning notice.

This inspection was carried out to check that the provider had met the requirements of the warning notice regarding the management of medicines. We found the necessary improvements had not been made.

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 'St James House' on our website at www.cqc.org.uk.

St James House provides accommodation for up to 30 people who require support with personal care. There were 23 people living at the service at the time of our inspection.

The service did not have a registered manager in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 provider told us a new manager had been appointed who would apply to register with the CQC once in post.

Staff had received training in the administration of medicines. Systems were in place to assess the competence of staff to safely administer medicines. Although people we spoke with did not express any concerns about how their medicines were administered by staff, we found a number of errors which meant people had not always received their medicines as prescribed.

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?
The service was not safe. Required improvements had not been made to the way medicines were managed in the service.

Requires improvement

St James 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 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.

We inspected the service against one of the five questions we ask about services: is the service safe? This was because the service was not meeting legal requirements in relation to that question.

We undertook an unannounced focused inspection of St James House on 20 October 2015. The inspection was completed to check whether the provider had met the requirements of the warning notice which was issued following the focused inspection in June 2015. The warning notice was issued as people were not protected against the risks associated with the unsafe management of medicines.

The inspection was undertaken by an adult social care inspector and a pharmacist inspector.

During the inspection we looked at the medication administration record (MAR) charts for all the people who used the service. We spoke with the acting manager, the staff member responsible for medication audits and the member of staff responsible for the administration of medicines on the day of the inspection. We also spoke with five people who used the service to check if they received their medicines as prescribed.

Requires improvement

Is the service safe?

Our findings

All the people we spoke with during this inspection told us they always received their medicines as prescribed. Comments people made to us included, "They [staff] give me tablets every morning. I can ask for painkillers and they will give them to me" and "Staff always remember to bring my medicines."

We observed that staff ensured people who had been asleep at the time of the medication round still received their medicines; this demonstrated person-centred practice. However, we also noted that one person was told they could not receive their 'as required' pain relief medicine until the medication round had started.

During the inspection we observed poor practice in the administration of medicines. This was because we saw the person responsible for administering medicines handle tablets without gloves and administer a tablet which had been dropped on the floor. This increased the risk of cross infection. We also observed the member of staff administer a controlled drug without this being witnessed by another member of staff as required under current legislation. However, when we checked the controlled drugs record later in the inspection we found the relevant entry had been countersigned. The purpose of countersignatures is to help protect both people who use the service and staff from the misuse of drugs. The fact that the entry was not countersigned until some time after the controlled drug had been administered meant the required procedure had not been followed. We also noted there were two other recent occasions on which the controlled drugs record had not been countersigned.

During the inspection we observed two people were given medicines which should be taken prior to food with their breakfast. This meant there was a risk that these medicines would not be effective. We also noted that two people had been prescribed a medicine to be dissolved in water before it was taken. However we noted that this medicine was given to both people with the rest of their medicines from the monitored dosage system without being dissolved. We discussed this with the staff member responsible for administering medicines on the day of the inspection. They told us they had been informed on a recent training course that it was not always necessary for this medicine to be dissolved in water prior to it being administered. However, we were concerned that this meant that the medicine was not being administered as prescribed.

When we checked the medication administration record (MAR) charts for all the people who used the service we noted a number of errors and omissions. We saw that the MAR charts for two people did not contain a photograph; this is important to ensure that staff are able to confirm the identity of people to whom they are administering medicines. The MAR charts for these two people also did not contain a record of any allergies from which they suffered. This meant there was a risk people might be given medicines which were not safe for them to take.

We noted that the MAR charts for four people contained missing signatures. One of the MAR charts had not been signed to confirm a person had received their blood thinning medicine. We therefore checked the controlled drugs record which was used by the service to monitor when this medicine had been administered. This record showed that the person had not received this medicine on the evening before our inspection. On our advice the acting manager contacted the anti-coagulant therapy team to check the action they should take to ensure the person did not suffer any ill-effects from this omission.

We reviewed the MAR chart for a person who had been readmitted to the service three days before our inspection following a period in hospital. We noted there was a discrepancy between this chart and the discharge summary provided to the home from the hospital. This was because the MAR chart contained a handwritten entry for a medicine which did not appear on the discharge summary. We asked the person responsible for this entry why this medicine had been included. They told us it had been in the bag of medicines returned to the home by the hospital. However, they informed us they had not done any further checks to ensure the medicine should be administered to the person. When we checked with the relevant ward at the hospital we were told the medicine had been placed in the discharge bag in error and should not have been administered to the person. We also noted that the discharge summary included information that the dose of one medicine prescribed to the person had been reduced from twice a day to once a day. From our review of the MAR chart we noted that since their return to the service the person had continued to be given the evening dose of

Is the service safe?

medicine which had been discontinued by the hospital. As a result of these two errors we informed the acting manager that a safeguarding alert should be raised with the local authority to ensure that, if necessary, an independent investigation could take place.

During the inspection we observed two people take their inhaler medicines. We noted that one person did not use a device which was prescribed for them to use to help ensure their inhaler was as effective as possible. We also noted that another person was given their inhaler which required a capsule to be pierced before inhaling. We observed that the staff member responsible for administering medicines did not check that the capsule was pierced before they gave the inhaler to the person concerned. When we checked the capsule after the person had finished using the inhaler we noted it had not been pierced. This meant that the person had not received the medicine contained in the capsule.

We looked at the systems in place for the administration of creams in the service. The staff member responsible for administering medicines on the day of the inspection told us they would sign the MAR charts to confirm creams had been administered. However, they told us care staff were responsible for administering creams.

We were told people who were prescribed creams had records in their bedrooms to show where the cream should be applied and for care staff to document when creams had been administered. We looked at the records relating to the administration of creams for two people who used the service. We noted one of these did not contain any record of cream being applied. We also noted that this person had cream in their bedroom which was not prescribed for them and which belonged to another person who used the service. We found that the cream medicine prescribed for the person was in the fridge unopened. This meant we could not be certain that staff had applied the correct cream.

When we checked the daily records for one person who used the service we noted there had been an incident recorded where the person told staff they had taken two capsules which they had found in their bedroom drawer at night. The record stated that as staff were uncertain what these capsules might be they had withheld the person's evening medicines. However the record stated that the MAR chart had already been signed to say the person had taken them. It was recorded that staff had contacted the on call manager who told them that it was not necessary to seek any further medical advice.

When we discussed this incident with the person who had been contacted as on call manager by staff, they told us staff had informed them that the person had not taken any medicines from their drawer but had merely dreamed this to be the case. We were told that night staff did not stay with people to ensure they had taken their medicines as prescribed. This meant there was a risk that people might not take their medicines or they could be taken by other people for whom they were not prescribed.

We looked at the personnel files for all of the staff responsible for administering medicines. We saw that all staff had completed recent training in the safe administration of medicines. We also saw that an assessment of each staff member's competence to safely administer medicines had been undertaken since our last inspection. We saw that two of these competence assessments had highlighted poor practice. This was because the two staff concerned had signed to confirm that medicines had been administered before they were offered to the relevant person who used the service. We were told that the staff members concerned had been advised that this was not the correct procedure to follow but no further checks had been made.

We spoke with the staff member responsible for auditing medication records. They told us they had been concentrating on ensuring that MAR charts were always signed by staff and that stocks of medicines were correct. We asked the staff member responsible for medication audits what action had been taken by the provider when staff had been found to have made medication administration errors. They told us some staff had been issued with improvement notices by the provider. We did not see evidence that the provider had taken any further action to ensure that only competent staff were responsible for the administration of medicines.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with the unsafe management of medicines.

The enforcement action we took:
We issued a warning notice