Care UK Community Partnerships Ltd

Hinton Grange

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

We carried out an unannounced comprehensive inspection of this service on 7 June 2016. During this inspection a breach of legal requirements was found. This was because people had not been administered all of their prescribed medicines and medicines were not safely managed.

After the comprehensive inspection on 7 June 2016, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook a focused inspection on 22 November 2016 to check that they had followed their plan and to confirm that they now met legal requirements.

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 'Hinton Grange' on our website at www.cqc.org.uk.

Hinton Grange is a two storey building located in a residential area of Cambridge. The service is registered to provide the following regulated activities. Accommodation for persons who require nursing and personal care and treatment of disease, disorder or injury for up to 60 people. At the time of our inspection there were 41 people using the service.

The home had a registered manager in post. They had been in post since 3 November 2015. 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.

At our focused inspection on 22 November 2016, we found that the provider had followed their plan which they had told us would be completed by 4 August 2016 and legal requirements had been met.

People were confident that their medicines were administered in a timely manner. Arrangements were in place to ensure that there were sufficient quantities of medicines in place. The management of people's medicines was in line with guidance from organisations such as the National Institute for Health and Care Excellence. People received their medicines safely and as they had been prescribed.

While improvements have been made we have not revised the rating for this key question: to improve the rating to 'Good' would require a longer term track record of consistently monitoring the quality of the service and delivery of high quality care.

We will review our rating at the next comprehensive inspection.

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

The service was safe.

People's medicines were accurately accounted for.

Medicines were managed safely.

A sufficient quantity of medicines was in place to meet people's needs.

While improvements have been made we have not revised the rating for this key question: to improve the rating to 'Good' would require a longer term track record of consistently monitoring the quality of the service and delivery of high quality care.

We will review our rating at the next comprehensive inspection.

Hinton Grange

Detailed findings

Background to this inspection

We undertook an unannounced comprehensive inspection of this service on 7 June 2016. During this inspection a breach of legal requirements was found. This was because people had not been administered all of their prescribed medicines and medicines were not safely managed.

After the comprehensive inspection on 7 June 2016, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook an unannounced focused inspection of Hinton Grange on 22 November 2016. This unannounced inspection was completed by one inspector. This inspection was to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection of 7 June 2016 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 legal requirements in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before the inspection we looked at the Provider Information Pack (PIR). This is information we hold about the service and includes the number of notifications, the provider's improvement plans and a range of information sources including the PIR. We also looked at statutory notifications that we had received. A statutory notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with three people living in the home and two relatives, the registered manager and two nursing staff. We also observed people's care to assist us in understanding the quality of care people received.

We looked at two people's care records. We looked at records in relation to staff training, audit records and records in relation to the management and administration of people's medicines.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection of Hinton Grange on 7 June 2016 we found that people's medicines were not safely managed and some people had not been given their prescribed medicines. This was a breach of Regulation 12 (1), (2) (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 22 November 2016 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirement of Regulation 12 as described above.

From records viewed, and people and staff we spoke with, we found that since our inspection in June 2016 the registered persons had ensured that people's medicines were given as prescribed. We also found that medicines were managed safely.

Information and guidance was in place to ensure that in the event of any person's medicines running low a process would be triggered to reorder these promptly. Other improvements had been made by the registered manager in identifying a single point of contact at their pharmacy. This had been to help make sure that any potential for confusion in the ordering of people's medicines was minimised. One person told us, "I have four [tablets] in the morning and as far as I remember I get them every day." A relative told us, "Family member does get their medicines and [topical] creams. I am sure of that as they appear quite well." Another person said, "I don't have medicines as such; just paracetamol and I get these whenever I need them."

We looked at people's medicines administration record (MAR) charts on both floors of the service. This was to check that improvements in the management of people's medicines was safe. We found that the records for quantities held had been reconciled with those medicines in stock. All medicines were clearly labelled as to whom they belonged to as well as an accurate record of any refusals using authorised recording codes such as 'E' for a refusal. One person told us, "They [staff] give me my medicines and then write on the form [MAR]." We also found that the cessation and commencement of people's prescribed medicines had been completed as directed by the person's GP. This had been to make sure people's medicines did not run out of stock.

We saw that following our inspection in June 2016 the registered manager had provided staff with support to help ensure that the recording of administered medicines was accurate. An individual form for people's medicines had been put in place which showed the daily totals. This assisted staff in the identification of the point at which medicines were reordered. Other improvements had been in the timing of this reordering. This meant that new supplies of people's medicines arrived in good time. One nurse told us, "It's so much better now. I have had training on ordering medicines and we have time to put each person's medicines in place." Another nurse said, "We check at each shift handover that all medicines are accounted for. Any [medicines] which have been opened, refused by people or damaged are disposed of safely." We saw that the disposal of medicines was done safely. People could be confident that their medicines were administered and managed safely.