

Housing & Care 21

# Housing & Care 21 - Limestone View

## Inspection report

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## Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

# Summary of findings

## Overall summary

We carried out an announced comprehensive inspection of this service on 17 July 2015. We found that the service required improvement to become safe. This was because the systems for medicine administration did not protect people from the associated risks. We identified this as a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection, the registered provider submitted an action plan telling us the action they would take to make the required improvements.

This inspection was focussed to review the progress made by the registered provider in making sure people were kept safe from the risks associated with medicines management. 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 Housing & Care 21 – Limestone View on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

This focussed inspection took place on 6 December 2016 and was unannounced.

Housing & Care 21 – Limestone View provides personal care and support to older people who live in their own apartments. Some of the people who use the service are living with dementia. Apartments are located on one site in Settle around an office and communal areas. There are 50 apartments currently in use. The aim of the service is to support people to live independently.

At the time of our inspection there was no 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 current manager had applied to be registered with the CQC and their application had been accepted. However, they were advised by CQC registration to seek management training in care before they could be registered. The manager was aiming to complete this training by March 2017. In the interim, the registered provider has made arrangements for the regional manager to register as temporary manager.

The system for administering medicines had been improved to make sure that people received their medicines safely. Medicine records were clearly written and we found no unexplained gaps in recording. There were systems in place to identify any errors promptly. We found that appropriate action was taken where any errors had occurred. This meant that the previous breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had now been met.

Staff were confident about how to protect people from harm and understood how to identify if anyone was at risk of harm. Staff had received training in medicine administration and were kept aware of any changes or updates to procedure. Risks to people had been assessed and plans put in place to keep risks to a minimum.

## 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.

People were now protected against the risks associated with medicines.

Staff were confident of using safeguarding procedures in order to protect people from harm.

Risks to people had been assessed and plans put in place to keep risks to a minimum.

# Housing & Care 21 - Limestone View

## **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 registered 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 a focused inspection of Housing & Care 21 - Limestone View on 6 December 2016. This inspection was done to check that improvements to meet legal requirements planned by the registered provider after our comprehensive inspection on 17 July 2015 had been made. The team 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.

This inspection took place on 6 December 2016 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During this inspection we looked around the premises and spent time with two people in their apartments looking at how their medicines were managed. We looked at records which related to people's individual care. We looked at management and auditing records and other records associated with medicines management. These included team meeting minutes and policies and procedures.

We spoke with two people who received a service, the manager, a senior care assistant and two care

assistants.

# Is the service safe?

## Our findings

At our last comprehensive inspection on 17 July 2015 we found that the service required improvement to become safe. This was because the systems for medicine administration did not protect people from the associated risks. We identified this as a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection the registered provider submitted an action plan telling us the action they would take to make the required improvements.

At this inspection we found that the required improvements had been made. Some people who used the service were unable to take their own medicines safely and relied on staff to make sure they took their medicines as prescribed. This is called medicine administration. Each person who needed their medicine to be administered by staff had a medication administration record (MAR). This provided a record of medicine administration and identified which staff had been responsible. The service used MARs provided by Housing & Care 21.

The MARs we reviewed were clearly recorded and listed all medicines separately, including the time of administration and dosage. There were no unexplained gaps on the MARs we looked at. Each person had a medicines risk assessment which provided personalised information about how people preferred to take their medicines as well as highlighting any potential risks. Information included any allergies or possible side effects as well as the person's understanding of what the medicines were for. We noted that medicines were kept securely in locked cupboards in each person's flat.

Where people used 'as required' medicines there was information about how it was to be used and written confirmation that the person had capacity to decide if they needed the medicine or not. We noted that when 'as required' medicines were administered there was an explanation in care notes as to why it was needed. There were separate MARs for 'as required' medicines. These assisted staff in identifying which medicines had to be routinely administered and which medicines should be offered as needed. Each person who used the service had individual, detailed care plans for each 'as required' medicine they used. Information included any special instructions and administration guidelines.

We spoke with the medicines lead who was a senior care assistant. They told us, "I feel it is better than it was. We have worked hard as a team to get things up to scratch. I stress to staff that any errors are now treated more seriously". They described the ways in which the registered provider made sure medicines were managed safely. They were responsible for auditing the MARs and taking action where any errors were identified. They explained that MARs were checked every Monday and 'as required' medicines were counted to check there were sufficient amounts. If there were less than nine days supply left, they would order more. This made sure that medicines did not run out.

The medicines lead explained that when medicines were received they were signed for and staff signed again when they were delivered to people who used the service. They added, "I print off the new MARs and check they are correct. They are then countersigned by another senior. I also carry out spot checks on MARs when there has been a change in medicine or dosage. If a person has been discharged from hospital they

usually send a letter and we check for medicine changes. If there is no letter we will contact the doctor to see if anything has changed".

The medicines lead said that care staff were trained and then observed administering medicines on three occasions before being signed off as competent. The staff we spoke with confirmed this. One care assistant commented, "I had medicines training and I was observed before being allowed to do it". Another care assistant who had recently started at the service told us, "I'm a bit nervous about medicines. Management have been very supportive and I can go to them for anything. It has been really good here. Good support. I have had medicines training and showed how to use a MAR. I was signed off as competent. If we are pulled up it is done in a supportive way. It's such a good work force. We all keep an eye out for any errors or gaps".

Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. One person was prescribed a controlled drug in the form of skin patches. We saw that this had been given in line with administration instructions. Body charts were used to record where patches had been placed. This is considered good practice as it enabled staff to make sure they were placed on different parts of the body. Patches were also signed and dated so that care staff could double check when they had been applied. The medicines lead told us there were extra checks with controlled drugs. They explained, "We have to show an ID badge at the chemist. They won't give out more controlled medicines if there appeared to be a discrepancy between what has been received and what is ordered".

A new management 'pack' was being introduced in January 2017. This was held on a computer and we were shown how it worked in relation to medicines management. Each person who used the service was listed and there was space to record any medicines issues. The system provided a summary of concerns and supported the manager in identifying trends so that they could take appropriate action.

The registered provider kept a record of all incidents in relation to medicines. Records showed that action was taken to follow up on any concerns raised. The registered provider informed other authorities, such as North Yorkshire County Council and CQC, of serious incidents, as required. The manager took action to make improvements where concerns were identified. For example, there had been issues with the recording of medicines, identified three months ago. This had been discussed in a team meeting and a new coding system was introduced, which provided better clarity for staff. The staff team had also been reminded of their responsibilities in a memo. Records showed the since that time, errors had reduced.

At this inspection we did not look at staff recruitment or staffing levels. At our last inspection in July 2015 there were no issues in these areas and we identified no concerns during this inspection.