Hillgreen Care Limited

Hillgreen Care Ltd - 13 Ruskin Road

Inspection report

13 Ruskin Road
N17 8ND

Date of inspection visit: 30 June 2015
Date of publication: 07/08/2015

Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 13 December 2014 at which one breach of legal requirements was found. The registered provider did not manage medicines safely.

After the comprehensive inspection, 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 30 June 2015 to check that they had followed their plan and met legal requirements.

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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 Ruskin Road on our website at www.cqc.org.uk.

13 Ruskin Road is a six bed care home for people with learning disabilities. It is registered for the regulated activity, accommodation for persons who require nursing or personal care. On the day of our visit there were six people living in the home.

The home has a registered manager. 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.

Summary of findings

At our focused inspection on 30 June 2015, we found that the provider had not followed their plan and legal requirements had not been met.

We found that medicines were not administered appropriately which meant that people could not be confident that the management of medicines was safe.

We found a continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking enforcement action against the provider in respect of this breach.

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 consistently safe. We found that MAR (medicines administration records) were not recorded properly and one person was being administered with the incorrect dose of medicines.

No medicines audits were taking place . This meant that people may not have been receiving their medicines as prescribed

Requires improvement

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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 was 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 Ruskin Road on 30 June 2015. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 13 December 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 legal requirements in relation to the question safe.

The inspection was undertaken by one Care Quality Commission pharmacist inspector.

Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements.

At the visit to the home we spoke with the deputy manager and one support worker and we looked at six medicines administration records and the provider's medication policy and associated medication records.

Requires improvement

Is the service safe?

Our findings

Systems were not in place to ensure that people consistently received their medicines safely, and as prescribed.

We saw that appropriate arrangements were in place for obtaining medicines. Staff told us how medicines were obtained and we saw that supplies were normally available to enable people to have their medicines when they needed them.

As part of this inspection we looked at the medicines administration records (MAR) for all six people. We saw there were not appropriate arrangements in place for recording the administration of medicines. When people were prescribed a varied dose of medication the quantity being administered was not being recorded on the MAR chart. We saw one person who had been prescribed an increasing dose of medicine over a four week period had not had their dose increased each week. This meant the person was being administered the incorrect dose of medicines.

We saw that the providers medicines policy did not describe the process to follow if a person who was prescribed medicines went on leave .We were told that two people who used the service went on regular home leave. We checked how they received their medicines and saw staff put them in a dosette box which was labelled with the person's name, date and medicine name. We saw the label had to be signed by two members of staff. However, staff had no guidance to follow and risks associated with the process had not been assessed.

Records showed all staff who administered medicines had completed medicines management training in February 2015 and each member of staff had their medicines administration assessed in May 2015.

Medicines were stored safely and records showed that they were kept at the correct temperature, and so would be fit for use.

We saw the provider did not do any audits to check the administration of medicines was being recorded correctly.

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 The registered person failed to safely provide care to service users by a failure to properly and safely manage medicines.

The enforcement action we took:
We served a Warning Notice on the Registered Provider, to become compliant with the regulation by 31st July 2015