Oakwood House

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Are services safe?

Overall summary

Oakwood House is a rehabilitation unit for up to 9 patients with acquired brain injuries. There were seven patients at the time of our inspection. The service is run by Care + Limited as part of a rehabilitation pathway.

There was a manager in post who has applied to be the registered manager but this application had not been completed at the time of the inspection.

The service has been registered with the CQC since December 2013 to provide the following regulated activities:-

Assessment or medical treatment for persons detained under the 1983 Act.

Treatment of disease, disorder and injury.

This service has been inspected once before in April 2015. The service had been issued with a warning notice and four requirement notices. The requirement notices remain in place but following this inspection, the requirements specified in the warning notice were met.

Summary of findings

Contents

Summary of this inspection

Our inspection team

The inspection team consisted of one CQC inspector and one CQC pharmacist inspector.

Why we carried out this inspection

This focussed inspection was carried out to check if the service had met the requirements of the warning notice issued in April 2015.

How we carried out this inspection

This inspection was a focussed inspection. Therefore the inspection team looked at whether the service was safe in terms of the medicines management in respect to the deficiencies identified in the inspection in April 2015. The inspection did not focus on the areas of effectiveness, caring, responsive and well led.

During this inspection visit, the inspection team met with the hospital manager and an external consultant, employed by Careplus, to assist improving quality within the service over the past six months.

In order to gain an understanding of the improvements the provider had made to work toward the requirement for the previous warning notice, we checked the medicines records for all seven patients at the location. We also checked the stock medicines and the medicines management policy.

We looked at the care records of one patient in order to establish that mental capacity was established where covert medication was proposed.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- Medicines were obtained and stored safely.
- Recent medicines audits had identified improvements to be made.
- There were plans in place to simplify the systems for ordering medicines.

However,

- Medicines charts had not been signed by the GP for the month we visited.
- While current audits were complete and identified errors, audits which had taken place over the between May and September had identified issues which had not resulted in action taken to resolve issues identified as the same issues were identified at consecutive audits with no explanation given for lack of action between them.
- The policy which was in place did not reflect the current procedures in place which meant there was a risk of confusion.

Detailed findings from this inspection

Mental Health Act responsibilities

Not inspected during this visit.

Mental Capacity Act and Deprivation of Liberty Safeguards

Not inspected during this visit.

Services for people with acquired brain injury

Safe

Are services for people with acquired brain injury safe?

Assessing and managing risk to patients and staff

- Appropriate arrangements were in place for requesting stock medicines. Staff told us how medicines were obtained and we saw that supplies were available to enable patients to have their medicines when they needed them. We checked the medicines for all seven patients and saw no medicines were out of stock.
- Medication was stored securely in a clinic room. Medicines requiring cool storage where stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use.
- Controlled drugs were stored and managed appropriately according to medicines management legislation.
- Self-administration of medicines by patients was not taking place.
- As part of this inspection we looked at the prescription charts for all seven patients. We saw the prescriptions charts for medicines prescribed by the patients' GP had not been signed by the GP, who was the prescriber for the month of November. We were told the provider was implementing a new prescribing system, which meant only medicines prescribed by the consultant psychiatrist would be recorded on a prescription chart. Medicines prescribed by the patients' GP would be recorded on a medicines administration record (MAR) chart. We were told this was changing the week we visited this location and the MAR chart system was not embedded at the time of inspection.
- We checked if the instructions on the medicine labels were accurately recorded on to the prescription charts. We saw this was done correctly for all medicines apart from two medicines, out of over 80 medicines checked.
- Audits of medicines storage, and administration were taking place monthly. These had not taken place consistently for the six months prior to our inspection visit. However, they had taken place during the two months prior to our visit. We saw that these recent audits identified if there were any discrepancies between the labelled instructions and the doses on the prescription charts as well as other issues and that these were addressed through the auditing process.
- At the previous inspection, we identified that one patient who received covert medicines had not had a capacity assessment and a best interests decision had not been documented in relation to this. At this inspection, we saw that where patients had medicines administered by being put into food, capacity assessments were happening and being clearly documented. The records reviewed demonstrated that these where this occurred the patient had capacity and therefore a best interest decision was not needed.
- The medication policy and procedure which was in place when we visited did not reflect the way that medicines were managed at the time of the inspection. For example, the policy stated that medicines audits would be carried out monthly by the provider pharmacy. This was part of the policy dated July 2015 and in November 2015 this was not yet happening regularly , although it was planned. This policy did not reflect the system in place whereby medicines for physical health were ordered from the GP at the time of the inspection as the policy reflected a new medicines management process which was yet to be implemented This meant that the policy might have been confusing for members of staff who were trying to understand how medicines were managed at Oakwood House.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that the policies are current and clearly explain and embed the up to date medicines management system so that staff are able to work with it and adhere to policy guidelines.
- The provider should ensure that audits continue to take place regularly and that where they identify errors or issues which need to be addressed to improve the processes or practice of administering medicines, these actions take in a timely manner