Parkcare Homes (No.2) Limited

Devon House

Inspection report

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Date of inspection visit:
06 September 2016

Date of publication:
11 October 2016

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 16 March 2016 and six breaches of regulations were found relating to consent, risk management, nutrition and hydration, person centred care and good governance. In addition, the provider was not providing care in a safe way as they were not doing all that was reasonably practicable to ensure the safe management of medicines. Following the inspection we served a warning notice on the provider and registered manager requiring them to comply with the regulations for the safe management of medicines.

We undertook this unannounced focused inspection on 6 September 2016 to check that the provider had met the requirements of the warning notice. At this inspection we looked at aspects of the key question 'Is the service safe?' This report only covers our findings in relation to the focused inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Devon House'' on our website at www.cqc.org.uk.

Devon House provides accommodation, nursing care and support with personal care for up to 11 people. At the time of our visit, 11 people lived there who needed support due to acquired brain injuries or neuro disabilities.

The home had a registered manager, who was on leave during the inspection. Staff assisted us with 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.

During our focused inspection we found the provider had made considerable improvements with medicines. Medicines were stored and managed safely. Staff had been recently trained and new protocols were in place. Regular audits were being completed to ensure the management of medicines was safe and follow up action was recorded.

The home had met the requirements and regulations identified in the warning notice, although we need to see consistent improvements over time before we are able to change the rating of this service from Requires Improvement.

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 provider had made improvements to medicines storage and recording and administration so that people were receiving their medicines safely as prescribed.

We have not changed the services' rating from 'Requires Improvement' as we need to see consistent improvements over time.

Devon 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.

This unannounced focused inspection was undertaken by a CQC pharmacist on 6 September 2016. This inspection was arranged to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 16 March 2016 had been made with medicines.

We inspected the service against one of the five questions we ask about services: Is the service safe?

Before our inspection we reviewed the information we held about the service. During our inspection we looked at records relating to the administration of medicines for 11 people. We also looked at records relating to staff training. We spoke with a registered nurse and administrator who were on duty on the day of the inspection.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of the service on 16 March 2016, the provider had not ensured medicines were always managed properly and safely. Specifically, we found that medicines administration records (MAR) were not always completed accurately, entries in the controlled drug register were not clear and there were no instructions for the safe and consistent use of medicines prescribed 'as required'. We also found that some medicines were not stored securely and records indicated that some medicines had not been given as prescribed. Following the inspection we served a warning notice on the provider and registered manager requiring them to comply with the regulations for the safe management of medicines.

At this inspection we looked at records and information relating to the administration of medicines for 11 people currently living at the home. We saw improvements had been made to the storage and recording and administration of medicines. The home had met the requirements and regulations identified in the warning notice, although we need to see consistent improvements over time before we are able to change the rating of this service from Requires Improvement.

All of the people living at the home relied on staff to administer their medicines to them. Some people had medicines administered covertly, which was disguised in food or drink, when people did not have capacity. Capacity assessment had been carried out that it was in people's best interest to covertly administer medicines. The appropriate assessments and information was recorded to ensure that this was done safely and appropriately. Some people required thickened fluids or had their medicines and nutrition through a tube into their stomach. Instructions and guidance from relevant health professionals was available to staff and we saw that these were being followed.

Arrangements for ordering people's medicines were effective, and all prescribed medicines were available. Suitable returns and disposal processes were in use and we noted that medicines that were no longer needed were promptly returned to the pharmacy. MAR were completed clearly, providing assurance that people were receiving their medicines as prescribed. People's allergy status was recorded on their MAR and all other relevant information was documented.

New protocols had been written and were in use, describing how people needed their medicines prescribed 'as required'. These were detailed and focused on the individual needs of people.

Controlled drugs were suitably stored and clearly recorded. Checks were done at each shift change-over by two nurses. Fridge and room temperatures were monitored to ensure that medicines were suitable for use. Creams were stored in the treatment room and only removed when needed.

We saw that where people needed blood tests to maintain their health, this was done and the results acted upon appropriately. A clear care plan was in place regarding the dosage of one medicine that could vary with need. Staff were able to tell us how this was managed in practice; however the dose administered at each time was not recorded on the MAR and therefore less easy for subsequent staff to check.

People's medicines were regularly reviewed by their doctor and we saw that where people refused medicines staff referred them to their doctor for support. Some medicines were obtained from a different service and we saw that staff ensured that people received an uninterrupted supply which was important for their health.

Regular audits were completed on the process of medicines management, including spot checks. We saw actions had been taken as a result from the audit findings. All nurses had received recent training in medicine administration from their pharmacy supplier.