Hamilton Community Homes Limited

Hamilton House

Inspection report

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Ratings

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

Overall summary

We carried out a focused inspection of this service on 24 September 2015. The focused inspection was to follow up on the requirements identified at the comprehensive inspection of the service on the 18 and 20 May 2015.

We undertook this focused inspection to check upon the enforcement action we had taken against the provider and whether the provider now met the legal requirements. This report only covers our findings in relation to the requirement and information gathered as part of the inspection. You can read the report from our last comprehensive inspection, by selecting 'all reports' link for Hamilton House on our website at www.cqc.org.uk

We will carry out a further focused inspection in the future to follow up on the breach identified at the focused inspection of 24 September 2015 where a breach regarding governance was found.

The provider submitted an action plan following the inspection of September 2015 advising us of the action they would take to address the breach of regulations identified by the end of November 2015.

This inspection took place 17 November 2015 and was unannounced.

The registered manager had reviewed the management of medicines within the service and had made changes to the way in which medicine was brought into Hamilton House, administered and recorded. However this was not supported by a written policy and procedure.

We found people's records did not contain sufficient information where they had been assessed with regards to the self-management of their medicines. We also found people's records did not provided sufficient guidance for staff on the administration of medicine that was given as and when required.

Summary of findings

The registered manager had liaised with people who used the service to improve practices where people themselves ordered their prescriptions and collected their medicine from the pharmacist.

The registered manager had liaised with a range of health care professionals to review the practice of medicine management within the service; further meetings were planned involving the GP and the supplying pharmacist to bring about further improvements.

We looked at people's medicine records and found that they had been completed correctly which evidenced that people were administered their medicine as prescribed.

Training for staff in the management of medicine had been scheduled and additional training was being planned. The registered manager had reduced the number of staff involved in the management of medicine to promote safe practices. They told us they planned to put into place checks on staff's on-going competence once they had accessed training.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

Hamilton House had a 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.

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 with regards to medicine management.

People were administered their medicine as prescribed. However improvements were needed to ensure the management of medicine was further supported through improvements to written guidance and information.

Requires improvement

Hamilton House

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Hamilton House on 19 November 2015. This inspection was to check that improvements to meet legal requirements identified at the focused inspection of 24 September 2015 were met.

We inspected the service against one of the five key questions we ask about services: is the service 'safe'. This was because the service was not meeting some legal requirement.

The inspection was undertaken by a Pharmacist Inspector and an Inspector and was unannounced.

During our inspection we spoke with the registered manager and a team leader.

We spoke with two people about their medicine.

We looked at five people's medicine records. We looked at records for the receiving of medicine into the service and the returning of unused medicines to the pharmacist.

Requires improvement

Is the service safe?

Our findings

At our previous inspection of 24 September 2015 we found that the safe care and treatment of people using the service was not met as people's medicines continued not to be managed safely. On 5 October 2015 we issued a warning notice under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requiring the provider to become compliant with Regulation 12 2 (b) (f) (g) by 28 October 2015.

At this inspection we looked at the processes for ordering and storage of medicines and at records of medication relating to five of the 16 people who used the service. We found that improvements had been made in some areas of medicine management, however further improvements were required.

The registered manager told us that she had carried out a full review of medicines management in the service and she was able to describe a robust process for requesting prescriptions, checking them against the request, ordering medicines from the pharmacy and checking the order on receipt. The process wasn't documented in the form of a policy or written procedures although the registered manager told us she planned to do this once the process was fully established. The safe administration of medicine to people would be supported by a robust policy and procedure for staff to follow to promote good and consistent practice.

People using the service were supported to manage their own medicines where possible and we saw that risk assessments were carried out to make sure they were safe. The assessment record didn't include a list of medicines so it was unclear what had been assessed as safe for that person to manage themselves. We discussed this with the registered manager who told us they would take the appropriate action and update people's records to include the different medicines people were prescribed.

One person was prescribed warfarin – we saw that they had regular blood tests which were required to monitor their on-going health and that the current dose instructions were being followed. However the instructions were stored separately from the medication administration record (MAR) so the member of staff administering the medicine did not have them to hand and may not have been aware if the dose had changed. Guidance for staff on the administration of people's medicine which was readily available would promote people's safety with regards to their medicine. The registered manager told us they would take action and ensure the information was available.

In order to simplify the administration process, staff kept the current week's supply separately from the main stock. Those medicines which did not come in weekly packs had been re-dispensed by the staff and so were not in packs labelled by a pharmacist. We discussed this with the registered manager who told us they would review this practice and make the necessary changes.

There were no protocols in place to guide staff on how to administer medicines prescribed on a "when required" basis, for example for pain relief, so we could not be sure that people were given the medicine consistently and correctly. The registered manager told us that protocols would be developed and they would consult with the relevant health care professional where appropriate.

The registered manager and staff had made progress in establishing safe processes for the management of medicines since our last visit. There had been no audit of the medicines management process, although external pharmacy audits were planned.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with one person about their medicine and they were able to tell us why they had been prescribed their medicine. They told us that staff administered their medicine and that were happy with this arrangement. A second person showed us that they had a secure place to store their medicine in their room as they administered their own medicine. This showed that people were involved in their medicine management.

The registered manager had liaised with people who used the service to improve practices where people themselves ordered their prescriptions and collected their medicine from the pharmacist. This meant that people's views were considered when improvements were being made to people's medicine management.

The registered manager told us that one of the measures they had taken to promote the safe management of people's medicine was to restrict the number of staff whose

Requires improvement

Is the service safe?

task was to administer medicine to three. They had also introduced a system, which meant staff were not to be distracted when administering medicine, to promote safety.

People using the service were cared for by a range of health professionals who used different systems for prescribing and supplying medicines, which increased the complexity for staff. The registered manager told us they were working with other professionals involved in the supply of medicines including the pharmacist and the GP practice and that meetings to discuss issues had been arranged.

We looked at the records for 5 people which showed that medicines were administered in line with prescriber's instructions with correct stock levels remaining. We found people's medicines were available as needed. We found unused medicine had been returned to the supplying pharmacist.

A programme of refresher training was being provided by the pharmacy and the manager had developed a template for assessing the competency of the staff although this hadn't been implemented.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have a written policy and procedure for the management of people's medicine. Staff had not received training or had their on-going competency assessed in the management of medicine. People's records did not include sufficient information about the management of their medicines to ensure their medicine was administered safely and consistently. Systems for auditing medicine management were not in place.