Community Care Solutions Limited

Aspen House

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

Aspen House is located in Rushden, Northamptonshire. The service provides personal care and accommodation for up to 10 people with a learning disability and other complex needs. The service is split into two units, referred to as the 'house' and 'lodge', each with self contained kitchens and additional communal areas. On the day of our inspection there were 10 people living in the service.

At the last inspection the service was rated as Good. At this inspection we found although the service remained Good overall, that the rating for the safe domain had changed to Requires Improvement.

This inspection was prompted by an increased amount of statutory notifications detailing medication errors and system breakdowns. The information shared with CQC about these errors indicated potential concerns about the safe administration and management of medication. This inspection specifically focused on those areas.

People were provided with their medication in accordance with prescribed guidance, however we found that there was an issue in respect of the storage, disposal and recording of some medication. Systems were in place to ensure people's daily medicines were managed in a safe way, but these had not always been followed adequately. Although we found that these aspects had been identified by the provider prior to our inspection, and some action taken to make improvements, more time and further work was needed to fully implement and embed required improvements.

Further information is in the detailed findings below.

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 service was not always safe.

New systems had been introduced to ensure medication was managed safely. However we still identified some issues in respect of storage, disposal and recording of medication.

Aspen 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 inspection took place on 24 January 2017 and was unannounced. The inspection was undertaken by two inspectors.

We checked the information we held about the service and the provider. We saw that some recent concerns had been raised in respect of medication systems and processes and the impact these had upon people. We therefore undertook a focused inspection to ensure that people were kept safe. We found that we had received information about events that the provider was required to inform us about by law, for example, where safeguarding referrals had been made to the local authority to investigate and for incidents of serious injuries or events that stop the service.

During our inspection, we observed how the staff interacted with the people who used the service. We also observed how people were supported during individual tasks and activities.

We spoke with four people who used the service. We also spoke with the registered manager, the deputy manager, one senior carer and one member of care staff.

We looked at five people's medication records to see if their records were accurate and up to date. We also looked at further records relating to the management of medication, he service, including audits, to ensure that robust systems were being maintained.

Requires Improvement

Is the service safe?

Our findings

Prior to this inspection we received an increased amount of statutory notifications from the service which indicated that the systems and processes in respect of medication were not always effective. We had concerns about the way in which medicines were managed.

During this inspection, we saw that in both units of the service, medication was administered from the kitchen. In one area in particular, this meant that there was an increased risk of errors because people who lived at the service liked to sit in there and talk or undertake various activities. Staff acknowledged this was an issue and told us that at times, it could be hard to concentrate appropriately because noise levels were high.

Medication was stored in lockable cupboards within both kitchens. Although the cupboards were locked, they were not appropriate for the storage of medication as they were not fixed. We found that one of the medicines cupboards, had a loose door which meant there was a risk the medicines could be accessed. Staff told us that they had raised their concerns about these issues with senior management. The operational manager told us that they were looking into every aspect of the medication systems and processes to ensure that this was better delivered. Alternative options were being considered as a method of reducing medication errors, one being individual storage within people's bedrooms.

Since our inspection we have received confirmation that cabinets have been ordered for all ten people's bedrooms, with a view to medication being administered on an individual basis. It was hoped that this would reduce future errors from occurring.

Staff told us that all liquid and topical medication should have the date of opening written on it, however, we found three open bottles with no indication of when they had been opened. This meant that there was potential for staff to administer medication which was passed its expiry date and therefore not as efficacious as it should be.

We also found one gap in the controlled drug book where medication had only been signed for by one staff member on 9 January 2017. Through discussions with staff we identified that the service was treating one specific medication as a controlled drug, which meant they although they were recording it in the controlled drugs book, they were not ensuring it was kept in a separate locked cabinet. We later checked this with pharmacy specialists who confirmed that the medication in question was exempt from being treated as a controlled medication. The operational manager told us they would adopt their practice accordingly.

Despite the discrepancy in only one staff member recording the administration of controlled drug on 9 January 2017, we found that the stock amount of medication reconciled, which meant that the person had received their prescribed medication. We spoke with staff about this omission and they explained the procedure for following up gaps in recording. We later spoke to the operational manager, who confirmed this process had been followed; records confirmed this to be the case.

Staff told us that as part of measures to reduce further errors, excess stocks of medication had been returned to the local pharmacy. We reviewed the three returned medication books that were in use, and found that although these detailed the medication that was intended to be returned, it did not confirm that medication had actually been collected. The person collecting the medication had not signed to acknowledge safe receipt; the service could not evidence that it has physically left the premises. We discussed this with staff who acknowledged our concerns. They contacted the pharmacy to ask for a new returns book for each unit to minimise future issues.

People told us that they got their medication when they needed it. One person said, "Yes, they give them to me when I need them. I can ask for them as well when I need something." Another person told us, "I have my tablets at 8am and 8pm, I know what they are for and I get them on time."

During this inspection, we observed some of the morning medication round. Two permanent members of staff, each took responsibility for administering medication in a different part of the service; ensuring people received their medication at the right time and in accordance with their prescriptions. We found that although the provider policy stipulated that medication could be administered by only one staff member, that to reduce potential errors and in line with best practice, two staff members were now undertaking this role. This change had been implemented by the operational manager following the increase of the medication errors in an attempt to drive improvements in the medication systems.

We observed staff to be confident in terms of recognising and understanding the purpose of medication they were giving to people. They were careful in checking medication before they administered it to people, only signing medication administration records (MAR) once medication had been given as prescribed.

We checked MARs and found these had been completed correctly, with the reverse of charts used to denote when people had received PRN (as required) medication. Where medication was given for a specific reason, it was clear as to the reason and how many tablets had been given. This meant that staff had an accurate record of what had previously been given.

People had an individual medication profiles that contained a clear photograph of the person they related to. The operational manager explained, and showed us, how new records were soon to be commenced. These would contain all relevant information relating to medication for one person; so rather than staff having to use numerous records, everything would be together. Again it was hoped that this would simplify systems and provide staff with more clarity about stock balances and medication guidance, enabling more robust auditing to take place.

For the medication errors that had occurred in the service, the operational manager advised that internal investigations had taken place to establish the reason behind the error. Staff told us that those with responsibility for giving medication had been retrained. One said, "The training reminds us what we need to do; it's important." Another staff member told us, "We have all been given more training. It is helpful; we want to get things right." Records confirmed that training had taken place to provide staff with refresher skills on the importance of safe medication processes.

The operational manager acknowledged the concerns we had raised clearly outlined further measures that they had started to introduce; to ensure medication was managed safely in future. These included improving communication with the pharmacy, improved auditing of medication and developing a clear process about ordering medication before it ran out. It was clear that action had been taken to strengthen the arrangements regarding the management of medication. However, more time and further changes were required to ensure people consistently received their medication on time, and in a safe way.