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St James House

Inspection report

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Ratings

Is the service safe?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 21 January 2015 at which a breach of legal requirements was found. This was because the systems to ensure the safe administration of medicines in St James House were not sufficiently robust to ensure people who used the service were adequately protected.

After the comprehensive inspection the provider wrote to us to say what they would to meet legal requirements in relation to the breach. We undertook an unannounced focused inspection on 15 June 2015 to check that they had followed their plan and review whether they met the legal requirements in relation to the management of medicines.

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 'St James House' on our website at www.cqc.org.uk.

St James House provides accommodation for up to 30 people who require support with personal care. There were 27 older people living at the service at the time of our inspection.

The service had a registered manager in place. 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.

At our focused inspection on 15 June 2015 we found that not all the required improvements had been made to the management of medicines in St James House. This meant there was a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of this report.

The provider had made some improvements to the management of medicines in the service, including adding information about allergies to the medication administration record (MAR) charts and introducing a system to assess the competence of staff to safely administer medicines. Information was available to staff to advise them when 'as required' medicines should be given and staff had recorded how many tablets had been given when people were prescribed a variable dose of their medicines. However we found some MAR charts

Summary of findings

were not fully completed and systems to ensure the safe management of controlled drugs in the service were not always followed by staff. In addition systems to ensure handwritten MAR charts were an accurate record of the medicines prescribed were not sufficiently robust to ensure people who used the service received their medicines as prescribed.

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 safe. This was because not all the required improvements had been made to ensure people were protected from the risks associated with the unsafe management of medicines.

Requires improvement

St James 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.

We undertook an unannounced focused inspection of St James House on 15 June 2015. The inspection was completed to check whether improvements to meet legal requirements planned by the provider after our comprehensive inspection on 21 January 2015 had been made. We inspected the service against one of the five questions we ask about services: is the service safe? This was because the service was not meeting legal requirements in relation to that question.

The inspection was undertaken by one adult social care inspector.

Before our inspection we reviewed the information we held about the service; this included the provider's action plan which set out the action they would take to meet legal requirements in relation to the management of medicines.

During the inspection we looked at the medication administration record (MAR) charts for all the people who used the service. We spoke with the registered manager who was present for part of the inspection, the provider and the member of staff responsible for the administration of medicines on the day of the inspection. We also spoke with two people who used the service to check if they received their medicines as prescribed and looked at records in relation to the administration of medicines in the service.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of St James House on 21 January 2015 we found that people were not protected against the risks associated with medicines. This was because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 15 June 2015 we found not all the required improvements had been made. This meant there was a breach of regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we arrived at the service at breakfast time we spoke with the two people who were sat in the dining room. They both told us they had been given their medicines. We checked the medication administration record (MAR) charts for these two people and noted the person responsible for administering medicines had not signed to confirm the medicines had been given. We then checked the monitored dosage system used in the service to see whether other people had been given their medicines. We found 21 people had been given their medicines at breakfast time on the day of our inspection but the administration records had not been completed to confirm this for 16 people.

We spoke with the member of staff responsible for administering medicines on the day of the inspection to check their understanding of the correct procedure to follow to ensure all medicines were safely administered. They told us they had received training in the safe administration of medicines and were aware that they should sign the MAR chart for each person immediately after their medicines had been administered. They could not give any explanation as to why they had not followed this procedure on the day of our inspection. We also noted this member of staff sign the MAR chart before they had administered a pain relief patch to one person who used the service. They told us this was because they knew the person would not refuse the medicine. It is important to ensure all MAR charts are accurately completed to confirm people who use the service have received their medicines as prescribed.

We looked at the completed MAR charts for the period 1-15 June 2015. We noted there were omissions on the records for three people who used the service. We checked the stock of medicines against the MAR charts for one of these people and noted a minor discrepancy for one medicine. This meant we could not be certain the person had received this medicine as prescribed. We also noted arrangements had not been made to ensure the person received all their medicines as prescribed when they were away from the home at mealtimes.

At our inspection in January 2015 we found that a handwritten MAR chart had not been signed by the person responsible for creating it. The record had also not been checked for accuracy and signed by a second trained and skilled member of staff before it was first used. On this focused inspection we noted that there were handwritten MAR charts in place for six people who used the service. We noted only one of these records had been fully completed. Three records had not been countersigned and two records did not contain any signatures to confirm the accuracy of the records. This meant there was a continued risk that people might not receive their medicines as prescribed.

We spoke with two people who used the service regarding the support they received from staff in relation to their medicines. Both people told us they always received their medicines as prescribed. One person commented, “I have medicines four times a day. I always get them at the right time.”

At our inspection in January 2015 we noted that MAR charts did not contain information about any allergies people experienced. On this inspection we saw that this had been rectified and any allergies were now clearly documented on individual MAR charts.

At our inspection in January 2015 we were concerned that records relating to the administration of controlled drugs (medicines which are controlled under the Misuse of Drugs legislation) were not always signed by two members of staff to confirm these drugs had been administered as prescribed; the practice of dual signatures is intended to protect people who use the service and staff from the risks associated with the misuse of certain medicines. When we checked on this inspection we noted numerous occasions on which there had been a failure of staff to countersign the controlled drugs records. We discussed this with the registered manager who told us they had recently reminded staff of their duty to adhere to the policy

Requires improvement

Is the service safe?

regarding the countersignature of controlled drugs records. However, when we looked at the most recent medication audit completed by the registered manager, which covered part of the period for the records we had reviewed, we noted they had failed to identify the omissions we had noted in the records. This meant the system for auditing the administration of records was not sufficiently robust to help ensure people who used the service were protected against the unsafe administration of medicines.

When we checked the stock of controlled drugs held for six people who used the service we found these corresponded with the records.

We saw that the registered manager had introduced a system for recording in what circumstances 'as required' medicines should be administered. We also found that staff had recorded how many tablets had been given to people for whom a variable dose of their medicines was prescribed. This meant staff were able to check what medicines people had received.

When we looked at the records related to staff who administered medicines, we noted all had completed recent training and the registered manager had introduced a process to assess their competence to safely administer medicines.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations 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 People were not protected against the risks associated with the unsafe management of medicines.

The enforcement action we took:
We issued a warning notice