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**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 4 March 2016 and was unannounced.

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.

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 and was supported by a written policy and procedure.

Risk assessments had been carried out where people using the service administered their own medicine. These were regularly reviewed with the person and a member of staff to ensure people safety was promoted. People were encouraged by the service to achieve greater independence in the administration of their medicine as part of their care plan.

People's medicine administration records had been accurately completed and were consistent with the provider's policy and procedure. The stock of medicines on the premises which we checked were consistent with the records held by the service, showing people's medicine was being managed well.

Staff had undertaken training and had had their competency assessed for the management of medicine.

Systems were in place to audit all aspects of the management of medicine which had identified that the policy and procedure was being implemented well.

The Care Quality Commission (CQC) at the next comprehensive inspection will review medicine management to ensure good practice has been sustained.

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 safe.

People's medicine was managed safely by staff who had had their competency assessed and who had received training on medicine management.

Is the service well-led?

Requires Improvement

The service was well-led.

Governance audits for medicine management were in place and checks undertaken to ensure medicine was managed well.

Hamilton House

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Hamilton House on 4 March 2016. This inspection was to check that improvements to meet legal requirements identified at the focused inspections of the 24 September and 17 November 2015 were met.

We inspected the service against two of the five key questions we ask about services: is the service 'safe' and is it 'well-led'. This was because the service was not meeting some legal requirement.

The inspection was undertaken by a one inspector and was unannounced.

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

We spoke with one person about their medicine.

We looked at six people's records who administer their own medicine and three people's medicine records whose medicine is administered by staff and the storage of these medicines.

We looked at the policy and procedure for the management medicine along with staff training and audits with regards to medicine and its management.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection of 17 November 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. We found a written policy and procedure was not in place for the management of medicines. Information about monitoring people's health with direct links to medicine administration was not managed safely. Systems for the management of medicine which is administered as and when required were not robust. And staff responsible for medicine did not all have up to date training or had their competency to manage and administer medicine assessed.

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

We received an action plan from the provider which outlined the action they were going to take which advised us of their plan to meet the regulation by 29 February 2016. We found that the provider had taken the appropriate action.

We spoke with one person who told us they were administering their own medicine and had a week's supply at a time, which initially had been for two days. They told us that they kept their medicine locked in a cabinet in their room and that they kept the key safe. They agreed to show us their medicine in their room, they spoke with us about their medicine and understood why it had been prescribed and told us at what time they took it. They told us that staff spent time with them to talk about their medicine and that they enjoyed managing the medicine themselves and were positive that they had managed it well.

We looked at the risk assessments and care plans of people who administer their own medicine. We found that the assessment identified the potential risk and what measures were to be put in place to manage risk. Measures to manage risk included regular checks to be carried out by staff to ensure people had taken their medicine as prescribed and that they were storing their medicine safely. Risk assessments were reviewed monthly or more frequently if required and involved a discussion with the person using the service and a member of staff. We found that people's level of autonomy was increasing and that people were administering their medicine for greater periods of time independent of staff. This showed that people's safety was being maintained and their right to make decisions and be involved in their care was being promoted.

We looked at the records of three people whose medicine was managed by staff. We found that people's records had been completed appropriately and that people's medicine was being stored safely. The quantity of people's medicine we looked at was consistent with written records, which showed people's medicine was being managed safely. Medicine that was not used was returned to the pharmacist and records signed by staff and the pharmacist confirmed this.

The registered manager had put into place a written policy and procedure for the management of medicine and its storage, which included all aspects of medicine management. The document had been signed by

staff to indicate they had read and understood it.

Where people were prescribed warfarin we saw that they had regular blood tests. The current dose was being followed and instructions for the management of warfarin were stored with the person's medication administration records. This to ensured staff had access to information should the dose have changed to promote people's safety.

The registered manager had written to health care professionals who had prescribed medicine that was to be administered as and when required. They had requested a written protocol providing guidance to as to the medicines use. The registered manager was waiting for health care professionals to provide the requested information. People who were prescribed medicine that is to be taken as and when required were knowledgeable about the medicine and its use and asked staff for their medicine when they required it.

Records showed staff had completed medicine training and were waiting for their work to be validated by the pharmacist. The registered manager had carried competency assessments on staff to ensure they were competent in the management and administration of people's medicine.

The Care Quality Commission (CQC) at the next comprehensive inspection will review medicine management to ensure good practice has been sustained.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection of 24 September 2015 we found that people were at risk as governance systems to manage and monitor risk were ineffective with regards to the management of medicines.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received an action plan from the provider which outlined the action they were going to take which advised us of their plan to meet the regulation by 9 November 2015.

We found that the provider had taken the appropriate action. The registered manager had carried out audits to ensure that medicine within Hamilton House was being managed well. The audit recorded that the procedure for the recording, storing, administration and disposal of medicine was being followed.

Staff carried out checks to ensure people who administered their own medicine were doing so safely, which was consistent with people's individual risk assessments. We found that where concerns had been identified then a record of the discussion between the person using the service and staff had been recorded and included the necessary steps to promote the person's safety. This showed that governance systems in relation to medicine were robust and people were consulted.

The Care Quality Commission (CQC) at the next comprehensive inspection will review medicine governance systems to ensure good practice has been sustained.