Sevacare (UK) Limited

# Sevacare - Bedford

## Inspection report

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Date of inspection visit: 28 October 2015
Date of publication: 18/12/2015

## Ratings

### Overall rating for this service — Good

### Is the service safe? — Requires improvement

## Overall summary

This inspection took place on 28 October 2015 and was unannounced.

At our previous inspection on 3 and 4 June 2015, we found that people were at risk of not receiving their medicines as prescribed. This was because there were inconsistencies in how their medicines were administered and managed. Therefore, people were potentially at risk of harm.

This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider to provide us with an action plan to address this and to inform us when this would be completed. After the comprehensive inspection, we undertook this focussed inspection to check that the provider had made improvements and to confirm that they now met legal requirements.

This report only covers our findings in relation to the outstanding breach of regulation. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for 'Sevacare Bedford' on our website at www.cqc.org.uk.

Sevacare Bedford provides care and support to people in their own homes.

The service had a registered manager. 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.

During this inspection, we found improvements had not been made. There continued to be inconsistencies in how people's medicines were administered and managed by the service. Therefore, there was a potential risk of harm to people's safety.

# Summary of findings

The provider remained in breach of Regulation 12(2) (g) 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.

# 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?**

People were not safe

Inconsistencies in how people's medicines were safely administered and managed persisted. As a result there was a potential risk of harm to people's safety.

**Requires improvement**

# Sevacare - Bedford

**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.

At the last comprehensive inspection on 3 and 4 June 2015, we asked the provider to make improvements to meet the legal requirement in relation to the proper and safe management of people's medicines.

The provider sent us an action plan stating how they planned to meet the legal requirement.

We undertook an unannounced focussed inspection at Sevacare Bedford on 28 October 2015, to check that improvements to meet the legal requirements had been met. We found there was continued evidence of failure to meet the legal requirements in relation to the proper and safe management of people's medicines.

The inspection was undertaken by one inspector.

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 previously meeting the legal requirement in relation to the safe domain.

Before our inspection we reviewed the information we held about the service. This included the provider's action plan, to meet the legal requirement. We also reviewed information we held about the service that included statutory notification, which the provider had sent to us. A statutory notification is information about important events, which the provider is required to send us by law. We contacted the local authority that commissioned the service to obtain their views.

We spoke with the branch manager and a team leader to gain their views on what improvements had been made to achieve compliance. We looked at the Medication Administration Record (MAR) sheets for 11 people who used the service. We also looked at training records, minutes from staff meetings and other records relating to the management of the service.

Requires improvement

# Is the service safe?

## Our findings

When we inspected Sevacare Bedford on 3 and 4 June 2015, we found people who used the service were at risk of not receiving their medicines as prescribed. This was because there were inconsistencies in how medicines were administered and managed. Therefore, there was a potential risk of harm to people's safety.

This was a breach of Regulation 12 (2) (g) Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider submitted an action plan detailing the actions they would be taking to ensure proper and safe management of medicines. They told us compliance would be achieved by October 2015.

We inspected the service on 28 October 2015 to assure ourselves that improvements had been made.

During this inspection we looked at the arrangements in place for the safe administration of medicines and found that people continued to be placed at risk because of unsafe medication practices.

We examined eleven people's medication administration record (MAR) sheets and found anomalies with six of the MAR sheets we examined. For example, there were unexplained gaps on some people's MAR sheets. Where we found that entries had not been completed, we looked at people's daily progress notes to see if medication administration had been recorded. We found in some instances no entries had been made. Therefore, we were unable to establish if people had received their medication as prescribed. In other instances there was information recorded on the daily progress sheets that medicines had been administered; however, the MAR sheets had not been completed to reflect this.

We found that a number of entries on MAR sheets were illegible. We saw one particular code had been used on a person's MAR sheet; however, there was no information to indicate the meaning of the code. There were occasions people had been prescribed for particular creams to be applied. The area where the cream was to be applied was not recorded on the MAR sheet. Therefore, we could not be certain that the systems in place to ensure proper administration and safe management of people's medicines were safe.

This was a continued breach of Regulation 12 (2) (g) Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us that since our inspection in June 2015, staff had been provided with further training in the safe handling and administration of medicines and a team leader had been deployed to work in the community. Their role was to shadow staff to ensure they were following best practice in relation to proper administration and safe management of medicines. The team leader was also responsible for auditing people's MAR sheets and to carry out spot checks to ensure people's safety and well-being were promoted.

We saw evidence that twelve training sessions on the safe handling of medicines had been provided to staff. We found after completing training that staff knowledge and competencies had been assessed. This was to ensure that the training had been embedded. We saw minutes of staff meetings held. Medicine administration was an agenda item at these meetings. Staff highlighted issues relating to some codes used on the MAR sheets. The branch manager told us that these issues had been addressed. We also saw evidence that spot checks and assessments of some staff's practice had been undertaken. This was to ensure they were working in line with best practice and delivering care and support in line with people's support plans. We saw evidence that a sample of MAR sheets were audited to ensure they were completed fully. Where anomalies had been identified the staff members responsible for these anomalies had been temporarily stopped from administering medicines until they had been provided with further training.

The branch manager told us that the organisation's medication policy provided guidance for staff to ensure people's medicines were administered safely. We saw a section in the policy which stated that when medicines were administered, the MAR sheet and the daily progress sheet should both be signed.

This section is primarily information for the provider

# Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>There were inconsistencies in the proper and safe management of people's medicines. There was the potential risk of harm to people's safety. This was because people's medicines were not administered and managed safely.<br><br>Regulation 12 (1) (2) (g) |

**The enforcement action we took:**