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Crossroads House Care Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good

Overall summary

We carried out an announced comprehensive inspection of Crossroads House on 6 January 2015. A breach of the legal requirements was found. This was because the arrangements in place for the administration and management of medicines at the service were not robust. There were gaps in the medicine records between 18 December 2014 and 4 January 2015 where staff had not signed to show they had given a person their medicines at specific times of the day as prescribed. The service did not have robust arrangements in place for the recording of controlled medicines (CD's). The records of stock held by the service did not agree with the CD's actually held. An audit carried out by an external pharmacist had identified these concerns in July 2014 and made recommendations that this issue be regularly monitored. This recommendation had not been actioned.

After the comprehensive inspection the registered provider wrote to us to say what they would do to meet the legal requirements in relation to the breach. As a result we undertook a focused inspection on the 21 May 2015 to check they had followed their plan and to confirm they now met legal requirements.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Crossroads House on our website at www.cqc.org.uk

Crossroads House is a care home for 44 older people who are living with dementia. At the time of the focused inspection on 21 May 2015 there were 35 people living at the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

At this focused inspection we found the service had commenced regular audits of the medicine records which had showed a considerable reduction in the amount of gaps where staff had not signed to show they had given a person their prescribed medicines. On the 6 May 2015 the service began using a new electronic medicine management system. All staff had received comprehensive training in the use of this new system prior to the go live date. The company who installed this system was continuing to provide support to the service to help ensure staff felt confident in the use of all the functions of the system. The electronic system required staff to sign each medicine administered and would not allow the staff member to move on to another administration until a signature was entered on the system. This meant all medicines had to be signed for at the time of administration.

Medicines that required stricter controls were also checked regularly to help ensure stock held by the service balanced with the records kept. The system highlighted each prescribed medicine that required stricter controls to staff ensuring that two staff members signed and witnessed its administration before the staff could move on to another medicine. This ensured that stock held balanced with the records kept at the service.

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 safe. We found action had been taken to improve the safety of the administration and management of medicines at the service.

As we consider the action to be sustainable we have revised the rating accordingly.

Good

Crossroads House Care Home

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 announced focussed inspection of Crossroads House on 21 May 2015. This inspection was completed to check that improvement had been made to meet legal requirements after our comprehensive inspection on 6 January 2015. We inspected the service against one of the five questions we ask about services; is the service safe? This is because the previous breach was in relation to this question.

The inspection was carried out by one inspector. Before our inspection we reviewed the information we held about the home. This included the information from the service regarding what steps they would take to meet the legal requirements.

We spoke to the registered manager, the operations manager and two staff. We checked the records relating to the administration and management of medicines at the service.

Good

Is the service safe?

Our findings

At the comprehensive inspection on 6 January 2015 we found it was not clear from the Medication Administration Records (MAR) if some people had received their prescribed medicines at the appropriate times. There were gaps in the records between 18 December 2014 and 4 January 2015, where staff had not signed to show they had give a person their medicines at specific times of the day. The service did not have robust arrangements in place for the recording of controlled drugs (CD's). These are medicines which required additional secure storage and recording systems by law. There was no audit trail to show what had happened to these medicines. Some people used pain relief patches regularly. These patches should have been returned to the pharmacy following use for safe destruction as they contained a CD. We found seven used patches for one person who lived at the service were being held. We were told the service did a weekly return to the pharmacy of medicines that were no longer needed. They had not been returned to the pharmacy. An audit carried out by an external pharmacist had identified this as a concern in July 2014 and recommended that these issues be regularly monitored by the service. This recommendation had not been actioned.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our focused inspection of 21 May 2015 we found that the provider had taken action to address these shortfalls. We found the service had commenced regular audits of the medicine records immediately following the last inspection. These audits showed a considerable reduction in the amount of gaps where staff had not signed to show they had given a person their prescribed medicines. Any staff who had not signed a medicine record when required had this raised with them personally. This continued to reduce the amount of gaps in these records. The service went on to install an electronic medicines management system and this system went live on 6 May 2015. The service now had six tablet computers which were used by staff to manage all aspects of medicine management at the service. All staff had received comprehensive training in the use of this new system according to their role. Staff used the tablet computers on top of the medicine trolleys during medicine rounds and had been shown how to protect people's confidential information by clicking an icon on the top of the screen, this blanked the screen while they were away from the device for short periods administering medicines. The system had a link to the British National Formulary, which is an on-line information service to support staff with their knowledge of specific medicines, side effects and contra-indications. All monitoring and ordering of further supplies of medicines was managed by the electronic system. All medicines that arrived and left the service, when no longer required, were recorded on the electronic system with a destination being requested. This helped ensure there was a clear audit trail of all medicines managed at the service.

Care staff, who may have been required to witness the administration of medicines that required stricter controls, were provided with training at a basic level. Senior staff who undertook medicine rounds regularly, received seven days of comprehensive training in the use of the system. There were also 'super users' who had been trained in how to draw reports and audits from the system as well as given the ability to monitor the system remotely from outside the service when required. The company who installed the system was continuing to provide support to the service to help ensure staff felt confident in the use of all functions of the system. The system was demonstrated to us at this inspection. The super users were able to monitor the progress of any specific medicine round in real time, as well as monitor the exact time when all medicines were given. We were told this was especially useful when monitoring the administration of medicines which had been prescribed for use as required (PRN). The use of PRN medicine was one of a range of specific reports which the super users could request from this system. If a PRN medicine was given for pain relief for example, the system prompted staff after a pre-set period of time to review the effectiveness of the medicine. This helped ensure that staff were aware if the medicine had the desired effect for the person or if they required additional pain relief.

The system clearly identified each person who required prescribed medicines at specific times of the day by making their photograph show in colour. All medicines were now administered from original packaging rather than the previously used blister packs. All staff had received specific training on administering medicines from original packaging. When a medicine was administered the system prompted staff to sign before they could move on to the

Good

Is the service safe?

next item. This prevented anyone from being given a repeated dose of a medicine in error, as it was clear when it had been given and at what time. If a medicine was not given to a person after being dispensed, the system prompted the staff member to give a reason from an extensive pick list. Staff were prompted to state if the medicine had then been destroyed or not, this ensured stock levels remained accurate and well managed.

We checked the medicine records for two people against the stock held at the service. We found one delivery of medicines had been entered twice on the system in error. This had lead to incorrect stock balances showing. We checked the history of the administration of all medicines for both people at the service. We found each prescribed medicine had been given at the correct time and all had been signed for by staff. The system had been in use for two weeks prior to this inspection. The day when the electronic system went live led to a short period of time when both systems were in use at the same time. This had led to some administrative errors and some stock balance discrepancies found at this inspection. We were told the company who were continuing to support the service with their initial use of the electronic system were due to return to the service in a week. This visit would review use of the system and review any administrative errors found. The service told us they would send us a report of this review.

We were told that when people left the service their medicines were audited to ensure stock held balanced with the electronic balance shown on the system. This helped ensure that any medicines that were taken out of the service by the person when they left would be clearly shown on the system and could be clearly audited.

The system highlighted to staff any medicines that had been prescribed for a person which required stricter controls. When these medicines were administered staff were prompted to have a second member of staff witness the administration, and two signatures were required before staff were able to move on to the next item. We checked the stock held by the service of medicines that required stricter controls against the electronic system balance shown and all agreed. If a person required a pain relief patch administered the electronic system prompted staff to record the position on the person's body where the patch had been placed. This helped ensure further patches would not be applied to the same place in the near future and helped reduce the risk of any local skin reaction. The system then prompted staff when the patch was due to be changed. This helped ensure people would received their medicine appropriately. The service told us that all pain relief patches, which contained a medicine which required stricter controls, were destroyed once removed from the person. This was in accordance with guidance they had been given by the community pharmacist. We did not find any used patches being held by the service as had been found at the previous inspection.

Following the last inspection the service had identified that visiting healthcare professionals had administered a medicine, that required stricter controls, but had not been provided with the record book in which to sign to record this. The service now had a system whereby any visiting healthcare professional who administered such a medicine would be required to sign the electronic system, the record book and have a second member of staff witness this.

Staff told us they found using the system was easy to use following their training and felt it was a positive improvement.

The service had addressed the concerns found at the previous inspection. At this focused inspection we found the service had taken action to meet the requirements of the regulation by installing an comprehensive electronic medicines management system which enabled the service to sustain this improvement.