Minster Care Management Limited

Karam Court Care Home

Inspection report

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Ratings

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 14 December 2015. A breach of legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Karam Court Care Home on our website at www.cqc.org.uk.

Karam Court is registered to provide accommodation and personal care for a maximum of 47 people. People living there have a range of conditions related to old age which may include dementia. On the day of our inspection 44 people lived at the home.

There was 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 2008 and associated Regulations about how the service is run.

Improvements had been made in relation to how medicines were managed and administered to people.

Staff competency checks were in place to ensure staff were administered medication safely.

Staff had received medicine management training and were given the opportunity to discuss medicines issues in team meetings.

Protocols for 'as required' medication were now in place but had not been placed with MAR [Medication Administration Records] charts.

More improvements were required in relation to the preparation and administration of medicines given to people. A daily record of stock balances was in place for each person's medicines, but staff did not always pass on information for further investigation when medicines had not been administered.

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 consistently safe.

Actions had been taken to improve the safety of medicines. However, further issues were identified which required improvement. Gaps in the administration of one person's medication had not been acted upon. The administration of medicines was not always undertaken following safe practice.

We could not improve the rating for safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Karam Court 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.

This inspection took place on 24 May 2016 and was unannounced. The inspection was carried out by one pharmacy inspector. The service was inspected against one of the five questions we ask about services: Is the service safe? The inspection concentrated on the safety of medicines, this was because at the previous inspection of 14 December 2015 the service was not meeting this legal requirement.

During our inspection we spoke with the registered manager, two team leaders and one person who lived at the service. We looked at the medication records of 12 people who lived at the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection of 14 December 2015, we could not be confident that some people's medical conditions were being treated appropriately by the use of their medication. We saw that where some medication needed to be administered 'when required' there was no protocol in place to direct staff with regard to in what circumstances this medication should be administered. The service provided an action plan of improvements they would make which included advice from a pharmacist from the supplying pharmacy. The reason for this inspection was to follow up on this action plan to ensure safe management of medicines. We found significant improvements had been made however we identified further issues relating to the safe management of medicines which require improvement.

We were shown documents of staff meetings to discuss medicine issues. A pharmacist from the supplying pharmacy had undertaken medicine management training. We were shown completed competency checks for trained staff to ensure safe handling of medicines. This showed that the service had taken positive action to improve staff awareness of the importance of safe management of medicines.

We looked at the Medicine Administration Record (MAR) charts for 12 people. Overall these records documented that people had been given their medicines as prescribed or a reason was documented to explain why the medicine was not given. Checks could be made on people's medicines due to the introduction of a daily record of stock balances for each medicine. Medicines prescribed to be given as 'one or two tablets' were accurately recorded. However, we identified that one person had no record of the administration of one medicine for four days which had not been reported or investigated. Staff we spoke with could not explain why the record had not been completed or reported as an incident to the manager. It is important that staff report medicine incidents so that lessons can be learnt to prevent them happening again and also to check that the person has not been harmed.

We found one external preparation which had been opened and used but had no name for identification label attached. There was therefore a potential for the external preparation to be used on more than one person with increased risk of contamination between users. This was bought to the attention of staff and it was immediately removed.

Detailed supporting information for staff to safely administer medicines prescribed 'when required' was available in people's care plans but not with people's MAR charts. For example, we looked at one person prescribed a medicine for anxiety to be given 'three times a day as needed' however it was not possible to know from the MAR chart when to give this medicine. We spoke with a team leader who was able to tell us when it would be given which shows they had a good understanding of the person's needs. We also spoke with one person who told us ''I don't take any medicines''. On checking we found they were prescribed one medicine to be given when needed. They had not required this medicine recently however there was no supporting information available with their MAR chart to inform staff when the medicine should be given. On discussing this with the registered manager it was agreed that a copy of the 'when needed' medicine protocol would be kept with peoples' MAR charts.

During the inspection we observed the preparation and administration of lunchtime medicines being given to people by two members of staff. This was not undertaken following safe practice. We observed one member of staff placing medicines into a medicine pot without the presence of the second member of staff. The second member of staff did not witness the medicine preparation before taking the medicines out to be given to the person. We further observed that at one point in the medicine preparation process there were three medicine pots on top of the medicine trolley containing medicines. This increases the risk of the wrong medicine being taken to the wrong person in error. On informing the registered manager we were told that this would be stopped immediately.

The security of one of the medicine storage rooms was identified as a potential security risk. This was discussed with the registered manager who agreed to risk assess the potential for access by unauthorised persons. Medicines were stored securely and safely in locked medicine trolleys and cupboards however we observed that two medicine refrigerators were not locked. It is important to ensure medicines are safely locked away at all times.