Pramacare

# Pramacare

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

| | |
|---|---|
| Is the service safe? | Good |

# Summary of findings

## Overall summary

This focussed inspection was announced and took place on 27 and 28 June 2017. We told the provider two days before our visit that we would be coming to ensure people and staff we needed to speak with would be available. At the last inspection completed in August 2016, we found a breach in the regulations relating to medicines. We found people were not always protected against the risks associated with the unsafe management and use of medicines. As a result we undertook this announced focussed inspection to review what improvements the provider had made in regard to their medicine management systems. At this inspection we found the provider had implemented a range of improvements and was compliant with the regulations.

Pramacare has 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.

Pramacare provides personal care and support to people who live in their own homes. The service is a registered charity and their stated vision is, 'A world where no-one is unfairly disadvantaged or excluded because of age or infirmity and where every person can enjoy life as they age'.

People were positive about the care and support they received from Pramacare staff. They told us, "The service is very good, I'm confident all the staff do the medicines safely".

The provider had implemented a range of systems to ensure people were protected against the risks associated with administering people's medicines.

There were clear systems in place to guide and support staff when administering creams to people. These involved the use of body maps so staff could easily see where and how to administer creams.

The provider had implemented a revised Medicine Administration Record (MAR), this was colour coded which staff said enabled easier, clearer guidance when administering people's medicines.

Where people wished to take their medicines after care staff had left there was a system of risk assessments completed for them to ensure they were safe to do this.

Staff had received thorough training in all areas of medicine management and administration and told us they found the training to be good and they felt well supported in their role.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

Systems for the management of medicines were robust and people received their medicines as they had been prescribed.

Risk assessments had been completed for people to ensure medicine administration was safe.

Staff had their competencies checked and received thorough training to ensure they were safe to administer medicines.

# Pramacare

**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 checked 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 Pramacare on 27 and 28 June 2017. This inspection was to check improvements had been made to the management and use of medicines. One CQC inspector undertook the inspection.

Before the inspection we reviewed the information we held about the service. This included reviewing the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law. We also requested the views of the local authority who commission the service.

We spoke with the registered manager, the chief executive, two members of staff and two people who use the service. We looked at four people's care and medicine records, medicine risk assessments, staff training records, a selection of MARs and reviewed meeting minutes, policies and supporting information which showed how the provider had made the improvements to their medicine management systems.

Good

# Is the service safe?

## Our findings

We spoke with a relative of a person that was using the services of Pramacare. They told us, "I feel very safe, the system has never failed at all, they always come in and make sure the medicine is given appropriately… it is quite a dangerous medicine but they always take all the precautions, make sure they have their gloves and aprons on and the staff are all very well trained, I can't fault them at all". Another person told us, "I have no concerns at all, they are all very effective and absolutely respectful, we have an established routine, I'm very happy with the service".

A member of staff told us, "The new system is much easier, it's all colour coded so it makes it easy for us…I get full support and can always call someone for advice if I need to". Another member of staff said, "Initially the changes we have made took a lot of work to put in place but now the system is so much easier, it's a lot better and a lot clearer for staff to follow".

At the previous inspection in August 2016 we found the systems in place for the management and administration of medicines had not always been followed, people did not have assessments or plans of care relating to the skin condition. There was no guidance in place to ensure that creams were applied in accordance with the prescriber's instructions.

At this inspection the registered manager showed us the new system that had been implemented to give staff clear guidance on administering creams to people. The system incorporated the use of a body map which showed staff exactly where to administer the creams, how much to use and how often to administer. The registered manager explained they had a couple of different versions of the body map and they would be implementing each version in different offices. They would then review with the staff to see which version the staff felt worked best.

At the previous inspection we found inconsistencies in some handwritten MAR's that staff had completed. Some MAR's did not include the names of the medicines, strength of the medicines or the times it should be administered. Some entries had not been checked and signed by a second member of staff to ensure that the correct instructions were being followed.

At this inspection we reviewed four people's MARs for a four month period and found improvements in the completion and recording of MAR's. The registered manager showed us the new MAR's they had implemented which were colour coded, enabling staff to clearly see which medicines to administer at what time. Staff told us they found this system much easier to follow. We reviewed MAR's that were handwritten, they showed the full instructions had been given with clear directions for the amount of medicine, the time it was to be given and how it was to be administered. The registered manager told us about the changes they had made in their medicine audits. The MAR's were now audited each month by a neighbouring locality manager, this allowed an independent quality check to be completed and errors and discrepancies were analysed each month and discussed at the monthly meeting to ensure learning from the errors could be taken forward.

Records showed, where handwritten entries had been made on MAR's two members of staff had signed and dated the record to ensure accuracy. Where a signature was missing, the quality assurance check had highlighted this and reported it as an error which was raised and discussed with staff for potential further training.

The new system enabled staff to record any medicines that had been given as a variable dose, for example a person being administered two pain relief tablets would have this clearly recorded. The registered manager discussed how they would record specific variable medicine such as warfarin. At the time of the inspection no person had warfarin being administered; however the system had been set up to enable staff to clearly record the amount and type of tablets which would reduce the risk of error. Records showed detailed guidance for staff to follow regarding information relating to specific medicines and their risks. For example, one person was on insulin to manage their diabetes. There was clear, detailed information in the person's care plan to guide staff on what signs to look for should the person become hyper or hypoglycaemic. There was guidance on what levels their blood sugars should be and what action to take in an emergency with current contact numbers for GP's and health professionals.

One person had been prescribed medicines that posed a high risk to people if handled without protective equipment. The provider had completed detailed risk assessments to ensure staff who administered these medicines were not put at any unnecessary health risks. Personal protective equipment was available and relatives told us the staff always made sure they wore their protective gloves and aprons when handling this medicine.

Some people preferred staff to take their medicines out of their original container and leave them in a container for the person to take in their own time. Detailed risk assessments had been completed for these people to ensure they were safe to take their medicines in this way.

Records showed all staff who administered medicines had their competencies checked and had received detailed training on administering specific medicines when required. We reviewed the providers support procedure for medication incidents and saw this provided clear instruction and guidance for staff to follow.

The registered manager showed us the new credit card sized 'aid memoir' that was being given to all staff. The information card identified the individual medication codes staff were to use and included prompts for staff on administering 'PRN' as required medicines. We also saw the new guidance for staff on completion of the providers PRN protocol form. The new form was due to be implemented in a neighbouring Pramacare service over the summer months.