Housing & Care 21

Housing & Care 21 - Springhill Court

Inspection report

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Ratings

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

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service on 30 September 2015. We found that the service required improvement to become safe. This was because the systems for medicine administration did not protect people from the associated risks. We identified this as a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection the provider submitted an action plan telling us the action they would take to make the required improvements.

This inspection was focussed to review the progress made by the provider in making sure people were kept safe from the risks associated with medicines management. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Housing & Care 21 – Springhill Court on our website at www.cqc.org.uk.

This focussed inspection took place on 1 December 2016 and was unannounced.

Housing & Care 21 – Springhill Court provides personal care and support to older people who live in their own apartments. Some of the people who used the service were living with dementia. Apartments are located on one site in Easingwold around an office and communal areas. The aim of the service is to support people to live independently.

At the time of our inspection 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 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 system for administering medicines had been improved to make sure that people received their medicines safely. Medicine records were clearly written and provided staff with the detail they needed. There were systems in place to identify any errors although we found one recent gap in recording which had not been identified. The registered manager took appropriate action in relation to this, which included staff refresher training in medicines administration. The staff we spoke with were confident about administering medicines in practice. This meant that the previous breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had now been met.

Staff were confident about how to protect people from harm and understood how to identify if anyone was at risk of harm. Staff had received training in medicine administration and were kept aware of any changes or updates to procedure. Risks to people had been assessed and plans put in place to keep risks to a minimum.

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.

People were now protected against the risks associated with medicines.

Staff were confident of using safeguarding procedures in order to protect people from harm.

Risks to people had been assessed and plans put in place to keep risks to a minimum.

Housing & Care 21 - Springhill Court

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 a focused inspection of Housing & Care 21 – Springhill Court on 1 December 2016. This inspection was done to check that improvements to meet legal requirements planned by the registered provider after our comprehensive inspection on 30 September 2015 had been made. The team inspected the service against one of the five questions we ask about services: is the service safe? This is because the service was not meeting some legal requirements.

The inspection was carried out by one inspector.

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR). The PIR 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.

During this inspection we looked around the premises and spent time with two people in their apartments looking at how their medicines were managed. We looked at records which related to people's individual care. We looked at management and auditing records and other records associated with medicines management. These included team meeting minutes and policies and procedures.

We spoke with two people who received a service, two senior care staff and the team leader. The registered manager was not present during our inspection so we spoke with them afterwards over the phone.

Good

Is the service safe?

Our findings

At our last comprehensive inspection on 30 September 2015 we found that the service required improvement to become safe. This was because the systems for medicine administration did not protect people from the associated risks. We identified this as a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection the provider submitted an action plan telling us the action they would take to make the required improvements.

At this inspection we found that improvements had been made. Some people who used the service were unable to take their own medicines safely and relied on staff to make sure they took their medicines as prescribed. This is called medicine administration. Each person who needed their medicine to be administered by staff had a medication administration record (MAR). This provided a record of medicine administration and identified which staff had been responsible. The service used Housing & Care 21 MARs.

The MARs we looked at were clearly recorded and listed all medicines separately, including the time of administration and dosage. Each person had a medicines risk assessment which provided personalised information about how people preferred to take their medicines as well as highlighting any potential risks. Information included any allergies or possible side effects as well as the person's understanding of what the medicines were for. We noted that medicines were kept securely in locked cupboards in each person's flat.

Where people used 'as required' medicines there was information about how it was to be used and written confirmation that the person had capacity to decide if they needed the medicine or not. We noted that when 'as required' medicines were administered there was usually an explanation in care notes as to why it was needed. However, care staff were also recording on the MAR when 'as required' medicines were offered, but not wanted by the person. There was inconsistent coding used on the MAR in these situations. Some staff used an X with an explanation on the back of the sheet, whilst some staff used an R to say the person had refused. Although we did not identify any concerns in the use of 'as required' medicines, the registered manager agreed that consistent coding should be used and said they would take action regarding this, which included refresher training for all staff in December 2016.

When medicine was received by the service, staff checked the medicines were correct and a receipt was provided. The team leader told us that if a person was discharged from hospital they requested written confirmation of any medicine changes so that they could be sure that administration was up to date and accurate. They added that any medicine changes were highlighted in the staff communication book. We saw examples which showed this process had been followed.

The provider had updated the medicines policy this year and we saw records that showed this had been discussed with the team during a recent meeting.

Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. We were told by the team leader that there was no one at the service who currently took controlled medicines.

There were management systems in place to make sure that medicines had been administered safely. The team leader explained that two senior members of care staff were responsible for carrying out an audit of MARs each week. The registered manager then audited 10% of completed MARs each month, as per company policy. The team leader explained that all staff were expected to give MARs a visual check when administering medicines so that errors could be identified promptly. Records showed that any errors were investigated and appropriate action was taken, such as staff supervision or extra training.

However, on one MAR we found a gap in recording from three days earlier. The medicine was not in the blister pack but the MAR had not been signed to show it was administered. The error had not been identified prior to our inspection. The team leader agreed that it should have been identified and said they would investigate what had happened.

A new management 'pack' was being introduced in January 2017. This was held on a computer and we were shown how it worked in relation to medicines management. Each person who used the service was listed and there was space to record any medicines issues. The system provided a summary of concerns and supported the manager in identifying trends so that they could take appropriate action.

The provider kept a record of all incidents in relation to medicines. Records showed that action was taken to follow up on any concerns raised. This included dialling 111 for advice and following up with any staff member involved. Any serious incidents were raised as a safeguarding concern with the local authority.

Records showed that all staff responsible for administering medicines had received appropriate training. The team leader explained that, after training, managers carried out observations and spot checks to make sure staff were competent. During induction new staff had the opportunity to shadow experienced staff to become familiar with medicines management.

Staff told us they were confident about administering medicines and that they had received suitable training. One senior member of care staff said, "Training gives the right support. I'm comfortable with administering medicines. Any errors, we contact a doctor or pharmacy for advice. Care plans and risk assessments give the information required". Another senior told us, "I feel that medicines management is a lot better now. We decided that our own charts (MARs) are better. We look at MAR weekly. We try to arrange call times in line with when medicines are needed, for example, half an hour before lunch".

At this inspection we did not look at staff recruitment or staffing levels. At our last inspection in July 2015 there were no issues in these areas. No concerns were identified during this inspection.