Hamilton Community Homes Limited

Hamilton House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 18 and 20 May 2015. A breach of legal requirements was found.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now meet legal requirements. This report only covers our findings in relation to those requirements and information gathered as part of the inspection. You can read the report from our last comprehensive inspection, by selecting 'all reports' link for Hamilton House on our website at www.cqc.org.uk

This inspection took place on 24 September and was unannounced.

The provider sent us an action plan that stated they had made the required improvements that met the legal requirement. We looked at people's medicine records and their medicines. We found that systems for the safe recording and administration of medicines were not robust or accurate. This meant there was not a clear audit trail of medicines and therefore the provider could not assure themselves that medicines were being managed safely and that people received safe and effective care and treatment.

Staff responsible for the management and administration of medicine were unable to provide an explanation for the anomalies we identified.

The provider submitted an action plan following the inspection of May 2015 advising us of the action they would take to address the breach of regulations identified. We found that the provider had introduced a process to monitor and ensure medicines were managed safely. However, our findings showed that the management of medicines remained ineffective and that quality of the service had not been monitored by the provider. This showed that the service was not well-led as the appropriate action had not been taken.

Summary of findings

We found that the system introduced for the recording of PRN medicine had not been effective. Staff advised us that medicines for use as and when required were now recorded upon receipt and counted. They told us that they would record in the medicine administration record the medicine that had been administered and total the balance remaining. This action had been taken, however the number of medicines on site were not consistent with records we viewed.

Hamilton House had 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.

We found breaches 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?

We found that action had not been taken to improve safety.

People's medicines and the systems for the management of medicines were unsafe and ineffective.

Requires improvement

Is the service well-led?

The service was not consistently well-led.

The provider had not taken the action consistent with their action plan to remedy the breach of the regulation and improve the management of medicines at the service.

Requires improvement

Hamilton House

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection on Hamilton House on 24 September 2015. This inspection was to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection of 18 and 20 May 2015 had been made.

We inspected the service against one of the five key questions we ask about services: is the service 'safe'. This was because the service was not meeting some legal requirement.

The inspection was undertaken by two inspectors and was unannounced.

During our inspection we spoke with two members of staff whose role within the service was that of team leader.

We looked at medicine records, which included medicines received into the service, medicine administration records and records for returning unused medicines to a pharmacist.

Requires improvement

Is the service safe?

Our findings

At our inspection of 18 and 20 May 2015 we found that the safe care and treatment of people using the service was not met as people's medicines were not managed safely. The records of two people found that the number of tablets on site did not correspond with the number of signatures on the medicine administration records. We also found that one person had two medicine administration records covering the same period of time for prn medicine, (medicine that is administered as and when required). A clear audit of medicines received into the service was not in place and poor record keeping meant the provider could not be confident that people had received their medicines as prescribes, which had the potential to impact on the health, safety and welfare of people using the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there was a continued breach of legal requirements, which meant people using the service were at risk as there medicines were not managed safely.

We found that three of the four people's medicine records we looked at to be inaccurate. The system for recording medicines received into the service, its administration and arrangements for returning unused medicine to a pharmacist were not safe or effective.

Staff were not able to provide explanations as to the anomalies identified and had difficulty in understanding the system they used for the recording of medicines into the service. People's medicine administration records were in some instances difficult to understand as staff entered a letter code when people did not attend the office at the time their medicine should be administered. If the person was administered their medicine later in the day then another signature was added. Additional information had been recorded on the reverse of the medicine administration record. However the process was not followed consistently making it difficult to establish an audit trail. This meant people could not be confident that their medicines were being managed safely and their health and welfare maintained.

Medicine records for the management of prn medicine were looked at. The medicine prescribed was recorded as was the number of tablets in stock. We asked staff what the signatures represented and we were told that these indicated that medicine had been administered and the number of tablets on site was accurate.

One person who was prescribed three different prn medicines. When we looked at the medicine administration records and the stock of medicine on site, we found there to be errors with all three medicines. An example being that the medicine administration records showed that there were 41 tablets in stock, however we found there to be 69 tablets.

The medicine administration records of a second person showed that the person had been administered medicine. However, there were 2 tablets extra within the packaging, which suggested the person's medicine had not been administered.

Records showed that people's medicine was prescribed by different health care professionals and that changes to people's medicines were not supported by written confirmation from health care professionals to those using the service or the provider. This meant there was not a clear audit trail to identify what medicine had been prescribed.

People were supported to be independent in the management of their medicine and in some instances people organised the ordering of their repeat prescriptions and the collecting of medicines from a pharmacist. In this instance the person then handed their medicine to a member of staff who recorded the medicine received into the service, which included the name of the medicine and the quantity. The medicine was then stored within a lockable facility and given to the person to self-administer consistent with their plan of care.

A person who managed aspects of their own medicine was given their medicine for them to administer themselves the following day. When we looked at the dates medicine had been prescribed on the bottle and the number of tablets received into the service and then compared this with the medicine administration records we found anomalies. There was not a clear audit trail and staff responsible for the management and administration of medicines when asked could not provide an explanation as to the anomalies.

Medicines to be returned to a pharmacist were kept in a box and the medicines return book recorded that

Requires improvement

Is the service safe?

medicines had not been returned since June 2015. The provider had changed the pharmacist who supplied medicines since our previous inspection. They had provided a new book to record medicine returns which had not been used.

Records showed that five staff had completed medicine refresher training in March 2015. A list of staff names and their initials used on the medicine administration records were kept in the room where the medicines were stored. This helped to identify the member of staff that had administered people's medicines.

Medicine audits were not available to view as they had been stored in the registered manager's office and were not accessible to staff.

Requires improvement

Is the service well-led?

Our findings

The provider submitted an action plan following the inspection of May 2015 advising us of the action they would take to address the breach of regulation identified. They advised us that prn medicines were now recorded upon their receipt into the service and counted. They told us that the medicine administration record would show that the medicine had been administered and the remaining balance of the medicine in stock. This action had been taken, however the number of medicines on site were not consistent with records we viewed.

The provider's action plan stated that audits would be carried out to ensure medicines were managed well. We were advised these had been carried out. However, the audits were not available for us to view on the day of our inspection as those were stored in an office which was locked and whose access was restricted to the registered manager. We asked a member of staff to forward these but they were not sent.

We found the provider had not taken the appropriate action to ensure that their approach to monitoring people's care was managed well. As records were inaccurate, which meant that the service with regards to the management of medicine was not well-led.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use service and others were not protected against the risks of ineffective governance because the provider did not have effective systems to monitor, identify shortfalls in the management of medicines. Steps were not taken to assess the risks to the health, safety and welfare of people and take measures to remove the risks.

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.