Hendon Community Care Centre Limited

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Inspection report

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20 July 2016

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Ratings

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

Summary of findings

Overall summary

We carried out a comprehensive inspection of this service on 24 February 2016. At that time we found the provider had a breached a regulation about the management of medicines. This was because medicine records were incomplete or inconsistent so it was not possible to know if people's medicines were being managed in a safe way. The provider sent us a plan showing what actions would be taken to address this.

We undertook this focused inspection to check they had followed their plan and to confirm they now met the 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 Hendon Community Care Centre on our website at www.cqc.org.uk

We found the provider had met the assurances in their action plan. There had been improvements to the completion of medicines records and how these were checked.

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

We found that action had been taken to improve the safety of medicines management.

Staff had had further training in medicines management. New medicines records were in place and these were being checked by senior staff.

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

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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 unannounced focused inspection of Hendon Community Care Centre on 20 July 2016. This inspection was carried out to check that improvements had been made following our comprehensive inspection on 24 February 2016. We 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 a legal requirement at the last inspection.

The inspection was undertaken by one adult social care inspector. During our inspection we looked at the medicines administration records for six people who used the service. We spoke with the registered manager, training director and risk assessment and monitoring officer.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of this service in February 2016 we found the provider had breached a regulation about the management of medicines. This was because medicine records were incomplete or inconsistent so it was not possible to know if people had been given their medicines or not. The provider sent us a plan showing what actions would be taken to address this. They said these actions would be completed by 1 June 2016.

We carried out this focused inspection on 20 July 2016. We checked whether the provider had made improvements to make sure people's medicines were recorded and managed in a safe way. We found improvements had been made.

The provider had designed a new medicines record to make it clearer which medicines each person was prescribed. Senior managers had held training sessions with the staff group to discuss the new medicines record. Staff had been reminded of their duty to make sure all the medicines records were completed at each dosage time or a code was used to denote why a medicine was not required.

Office staff were now responsible for checking medicines records to make sure these were completed correctly. Where any gaps were identified the individual staff members were required to attend a supervision session and further training. If staff members then continued to make errors it was intended that they would be removed from supporting people with their medicines until deemed competent. Staff had signed a written protocol about this to show they understood the consequences of any persistent recording errors.

We looked in detail at the medicine administration records for six people. We saw that the provider's actions had led to improvements in the way people's medicines were recorded and managed.