Unity Homes Limited

The Willows

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement

Overall summary

We undertook an unannounced focused inspection at The Willows on 21 July 2015. This inspection was undertaken to ensure that improvements that were required to meet legal requirements had been implemented by the service following our last inspection on 15 December 2014. During this inspection we found that the service was now meeting the requirements of Regulations under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We visited the home on 06 May 2014 and identified concerns about safe handling of medicines. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, in relation to the management of medicines. We undertook a follow-up inspection on the 22 September 2014 to see how the service had addressed the regulatory breach. We found that people were still not protected against the risks associated with the unsafe use and management of medicines.

We issued a 'Warning Notice' to the provider to ensure that improvements were made to ensure people were safe. This required the service to become compliant with Regulation 13 of the Regulated Activities Regulation 2010 regarding the management of medicines by the 01 November 2014. We visited the home on 15 December 2014 to check if improvement had been made in medicines handling to ensure people were protected against the risks associated with the unsafe use and management of medicines. We found that some improvements had been made, however overall insufficient progress had been made to protect people and we found that medicines were still not handled safely.

During this visit we also found that the service could not demonstrate they had consistent arrangements in place for the recording of people's consent. This was a breach

Summary of findings

of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, because the service had failed to maintain accurate records of people who used the service.

On the 24 June 2015, we interviewed the Managing Director of Unity Homes who was also the nominated individual for the service. They were interviewed under caution and admitted that the home had been in breach of regulation with regard to medication. They also told us that improvements had been made and systems had been implemented to ensure medicines were handled safely and people were no longer at risk from unsafe medication practices.

As part of this focused inspection, which took place on the 21 July 2015, we checked to see that improvements had been implemented by the service in order to meet legal requirements. This report covers our findings in relation to those requirements and additional concerns we received regarding the fire safety arrangements at the home. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'The Willows' on our website at www.cqc.org.uk.

We found systems were in place to ensure medicines were handled safely and people's health was protected. We looked at the records about medicines for the previous and current medication cycles and saw that robust arrangement were in place for obtaining medicines in a timely manner.

We saw that medicines were stored safely. We saw that the medicines fridges were now locked and that waste medication and creams were now stored securely.

We saw that people who were prescribed medicines to be given 'when required' had information recorded to guide staff as to how to recognise if people, especially those people who found communication difficult, needed their medication.

We found that there was clear information recorded to guide staff as to where to apply creams to ensure people were given the correct treatment. We saw that accurate records were made, which showed that creams were applied properly.

We saw that some people needed to be given their medicines covertly, secretly. There was adequate information available to guide staff as to the best way to hide their medicines so that they were given safely.

We saw that audits of medication were being carried out on a regular basis and the managers were aware of any shortfalls in medication handling and had taken effective actions to address them and prevent them from happing again.

When we visited the home on 15 December 2014, we found the service could not clearly demonstrate they had consistent arrangements in place for the recording of people's consent. This was a breach of Regulation 20 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010.

During this inspection we found the provider was now meeting the requirements of the regulation. We found that records were accurate, fit for purpose, were held securely and remained confidential. We looked at 15 care files of people who used the service. We found that consent records were now accurately completed and included dates and signatures of the person who used the service or their representative.

Before we undertook this inspection, we had also received information of concern regarding the fire safety arrangements at the home. As part of this inspection visit, we checked to see what arrangements existed and whether they protected people in the event of a fire. We found that suitable arrangements were in place to protect people in the event of an emergency.

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?

Inadequate

We found that action had been taken to ensure people were protected from the risks associated with the safe management of medication. We looked at the records about medicines for the previous and current medication cycles and saw that robust arrangement were in place for obtaining medicines in a timely manner.

We saw that audits of medication were being carried out on a regular basis and the managers were aware of any shortfalls in medication handling and had taken effective actions to address them and prevent them from happing again.

We found that suitable arrangements were in place to protect people in the event of a fire emergency. We saw that regular fire drills had been undertaken, which had been signed by staff confirming their attendance.

We could not improve the rating for 'safe' from 'inadequate' at this time, because to do so required evidence of consistent good practice over time. We also only looked at aspects relating to the breach of regulations, rather than looking at the whole question relating to 'safe.' We will review this during our next planned comprehensive inspection.

Is the service effective?

Requires improvement

We found that action had been taken to ensure people were protected from the risks associated with inaccurate record keeping.

We found that records were accurate, fit for purpose, were held securely and remained confidential. We looked at 15 care files of people who used the service. We found that consent records were now accurately completed and included dates and signatures of the person who used the service or their representative.

We could not improve the rating for 'effective' from 'requires improvement' at this time, because to do so required evidence of consistent good practice over time. We also only looked at aspects relating to the breach of regulations, rather than looking at the whole question relating to 'safe.' We will review this during our next planned comprehensive inspection.

The Willows

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 the Willows on 21 July 2015. This inspection was undertaken to ensure that improvements that were required to meet legal requirements had been implemented by the service following our last inspection on 15 December 2014. We also looked at the arrangements in place following concerns we had received about the management of fire safety at the home.

We inspected the service against two of the five questions we ask about services during an inspection, which were not meeting legal requirements, these included; 'Is the service safe' and 'Is the service effective.'

The inspection was undertaken by one adult social care inspector and a pharmacist inspector. Before the inspection, we reviewed all the information we held about the home. We reviewed statutory notifications and safeguarding referrals. We also liaised with external professionals including the local vulnerable adults safeguarding team. We also reviewed the action taken by the provider following our previous inspection, who had written to us explaining what action the service had taken to meet legal requirements.

During the inspection we spoke with the Managing Director of the service, managers for both The Willows and Bluebell Court and two nurses engaged in the administration of medication. We also looked at medication records, care files of 15 people who used the service, training records and Fire Safety management records.

Inadequate

Is the service safe?

Our findings

We visited the home on 06 May 2014 and identified concerns about safe handling of medicines. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, in relation to the management of medicines. After our visit the provider wrote to us to tell us how they would improve the way medicines were handled in the home by ensuring staff were fully trained. They also told us that monthly audits would be carried out in order to monitor standards and to identify any shortcomings.

We undertook a follow-up inspection on the 22 September 2014 to see how the service had addressed the regulatory breach. We found that people were still not protected against the risks associated with the unsafe use and management of medicines. We issued a 'Warning Notice' to the provider to ensure that improvements were made to ensure people were safe. This required the service to become compliant with Regulation 13 of the Regulated Activities Regulation 2010 regarding the management of medicines by the 01 November 2014.

The service then wrote to us telling us that improvements would be made by assessing the competency of the nurses who would be checking records at the end of their shift. An external consultant would also audit medicines each month. They told us better systems would be in place for ordering medicines and creams and that protocols would be put in place to make sure people were given their 'when required' medicines safely.

We visited the home on 15 December 2014 to check if improvement had been made in medicines handling to ensure people were protected against the risks associated with the unsafe use and management of medicines. We found that some improvements had been made, however overall insufficient progress had been made to protect people and we found that medicines were still not handled safely.

On the 24 June 2015 we interviewed the Managing Director of Unity Homes who was also the nominated individual for the service. They were interviewed under caution and admitted that the home had been in breach of regulation with regard to medication. They also told us that improvements had been made and systems had been implemented to ensure medicines were handled safely and people were no longer at risk from unsafe medication practices.

On 21 July 2015 we undertook an unannounced visit to the home to check if improvements had been made in medicines handling to ensure people were protected against the risks associated with the unsafe use and management of medicines. We found systems were now in place to ensure medicines were handled safely and people's health was protected.

As part of the inspection, we looked at records about medication and medication for 10 people who were living in the Bluebell Unit and six people living in the Willows on the day of our visit. We looked at the records about medicines for the previous and current medication cycles and saw that robust arrangement were in place for obtaining medicines in a timely manner.

We saw that medicines were stored safely. We saw that the medicines fridges were now locked and that waste medication and creams were now stored securely.

At this inspection we found that medicines were administered safely. Previously we found that people were at risk of being given their doses of medicines too close together. At this visit we saw that in the Willows the time of administering medicines (which must be given with a minimum time interval between doses) was recorded. This protected people from being given doses of their medicines too close together. We were assured that the records about the times medicines, such as Paracetamol, were given would be introduced throughout the whole Home.

We saw that people who were prescribed medicines to be given 'when required' had information recorded to guide staff as to how to recognise if people, especially those people who found communication difficult, needed their medication. Information needed to be more personalised so that staff could ensure that people were being given their medicines at the times they needed them.

We found that arrangements to give people their medication as directed by the manufacturers, especially with regard to food had now been made. We saw that medicines, which needed to be given before food, were now given at appropriate times.

Inadequate

Is the service safe?

The records about the use of thickener had been improved and there was clear information about how to thicken people's drinks to prevent them from choking. The records showed that people had been given thickened fluids appropriately, however we found that the prescribed containers of thickening powder were not kept safely. The manager ensured us that this would be rectified during our inspection visit.

We found that there was clear information recorded to guide staff as to where to apply creams to ensure people were given the correct treatment. We saw that accurate records were made, which showed that creams were applied properly.

When we compared the stock of medicines with the records we found that they showed that stock could be accounted for and people had been given their medicines as prescribed. We saw that all people had photographs on their medicines records, which enabled staff to administer the medicines to the right person.

We saw that some people needed to be given their medicines covertly, secretly. There was adequate information available to guide staff as to the best way to hide their medicines so that they were given safely.

We spoke with an agency nurse who was working their first day shift on the day of our inspection. They told us that the handover notes together with the information recorded and the assistance of care staff throughout the medication round had been good. The medication trolley was well organised and they could find all the medicines people were prescribed. They felt this helped them to administer medicines safely.

We saw that arrangements had been made for GPs to review people's medicines. When this resulted in doses being changed or medicines being added or stopped it was done speedily with people being given the correct doses of their medicines.

We saw that audits of medication were being carried out on a regular basis and the managers were aware of any shortfalls in medication handling and had taken effective actions to address them and prevent them from happing again.

Before we undertook this inspection, we had also received information of concern regarding the fire safety arrangements at the home. As part of this inspection visit, we checked to see what arrangements existed and whether they protected people in the event of a fire. We found that suitable arrangements were in place to protect people in the event of an emergency.

During our visit we looked at 15 care files of people who used the service. We found that each file contained a personal emergency evacuation plan (PEEP). This provided guidance to staff on the level of support the individual needed during an evacuation. We also found that each person who used the service had been graded by priority in respect of their mobility, so that staff were able to identify who to assist in the event of a fire.

We looked at Fire Safety Record Books for both the Willows and Bluebell Unit. This demonstrated that fire system weekly checks were undertaken in respect of the control panel, the fire alarm and fire extinguishers. We found that weekly door checks were undertaken and monthly emergency lighting checks took place. We saw that regular fire drills had been undertaken, which had been signed by staff confirming their attendance.

We looked at maps provided by the service, which divided the buildings into zones. This enabled staff to identify where an alarm had been activated and was located with the fire alarm panel. We looked at training records, which indicated that the majority of staff at the home had completed fire awareness training. Where people had not completed their training, training records indicated staff were currently engaged in the training.

Requires improvement

Is the service effective?

Our findings

When we visited the home on 15 December 2014, we found the service could not clearly demonstrate they had consistent arrangements in place for the recording of people's consent. This was because records had not been completed accurately of fully. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, because the service had failed to maintain accurate records of people who used the service.

During this inspection we found the provider was now meeting the requirements of the regulation. We found that records were accurate, fit for purpose, were held securely and remained confidential. We looked at 15 care files of people who used the service. We found that consent records were now accurately completed and included dates and signatures of the person who used the service or their representative. We found that records were located securely and could be promptly located by staff.