Integra Care Management Limited

374-376 Winchester Road

Inspection report

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Ratings

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

Summary of findings

Overall summary

We carried out a focused inspection on the 21 November 2016 to check whether 374 – 376 Winchester Road has taken action to meet the requirements of a warning notice we issued on 01 August 2016. This report only covers our findings in relation to these topics.

We undertook an unannounced comprehensive inspection at 374 – 376 Winchester Road on 13 July 2016 at which breaches of regulations were found. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for '374 -376 Winchester Road' on our website at www.cqc.org.uk.'

374 -376 Winchester Road is registered to provide accommodation and support for up to eight people who have a learning disability or autism. There were six people living at the home when we carried out the inspection.

The home had a registered manager. 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.

People were cared for safely living at 374 – 376 Winchester Road. Environmental risk assessments were managed effectively. The risks to people were minimized through risk assessments. There were plans in place for foreseeable emergencies and fire safety checks were carried out. Infection control procedures were in place and the manager had appointed an infection control lead. Processes were in place to enable the manager to monitor accidents, adverse incidents or near misses.

People received their medicines safely. Staff were trained and assessed as competent to support people with medicines. Medicine administration records (MAR) confirmed people had received their medicines as prescribed.

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

The service was safe.

Risks relating to the environment such as from fire or infection control were managed appropriately and people received their medicines safely.

We could not change the rating for this key question because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

374-376 Winchester Road

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. The inspection was carried out to check that improvements had been made to meet legal requirements, identified in a warning notice served after our comprehensive inspection on the 13 July 2016.

This inspection took place on 21 November 2016 and was unannounced. The inspection was carried out by two inspectors.

We reviewed the previous inspection report and information we held about the service including notifications. A notification is information about important events which the service is required to send us by law.

We spoke with the manager and two shift leaders. We observed staff providing care and support to people in the lounges, looked at care plans and associated records for three people living in the home. We checked accidents and incidents records, quality assurance records, medicines and some of the provider's policies and procedures.

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 some legal requirements.

Inadequate

Is the service safe?

Our findings

At a comprehensive inspection carried out on 13 July 2016, we found the service was not safe. We served a warning notice on the provider as the service was in breach of regulations and people's safety was compromised. The provider was required to take appropriate action by 21 August 2016. At this inspection we found that action had been taken and the areas we assessed were now safe.

At our inspection on the 13 July 2016 we found that people were at risk in the event of a fire. Fire extinguishers were kept secure in locked cases, with a key to open the extinguisher case in the event of a fire. A key was missing to an upstairs fire extinguisher and records of fire tests had not been completed since April 2016, which placed people at risk in the event of a fire. At this inspection improvements had been made. All fire extinguishers had keys fitted and staff showed us they were able to open these quickly in the event of an emergency. Records showed that weekly checks of fire detection equipment were being carried out. The manager had also added a check list to make sure the key was always available with the fire extinguishers at all times. Staff were aware of the action to take in the event of a fire and fire safety equipment was maintained.

At our inspection on the 13 July 2016 we found that people were at risk as environment risk assessments had not ensured the safety of the environment. Window restrictors were not suitable as they could easily be opened wide. We found an electric fuse box cupboard was full of potentially flammable items. Care plans stated hazardous substances should be locked away, and we found these all around the home. At this inspection improvements had been made window opening restrictors had been fitted in all rooms in the home. These allowed windows to be opened adequately for ventilation but not to open too wide placing people at risk. Chemicals dangerous to health were all locked away. A staff member told us, "I am always speaking to staff about the importance of keeping cleaning chemicals locked away." We checked the cupboard containing the electric consumer unit. Most of this cupboard had been cleared and we did see an improvement. However, we did find some potential flammable items. We spoke to the manager who informed us they had requested no items to be stored in there, and arranged for them to be removed and added to the daily shift leader checklist to check the cupboard was empty.

At our inspection on the 13 July 2016 we found that people were at risk as staff were not recording or reporting all accidents and incidents that occurred in the home and there was not an appropriate system to analyse incidents that occurred in the home. At this inspection we found staff were recording all accidents and incidents that occurred in the home. There were processes in place to enable the manager to monitor accidents, adverse incidents or near misses. This helped ensure that any themes or trends could be identified and investigated further. It also meant that any potential learning from such incidents could be identified and cascaded to the staff team, resulting in continual improvements in safety.

At our inspection on the 13 July 2016 we found that people were at risk as steps had not been taken to assess, prevent and control the risk of infection. The home had not been cleaned effectively and we found a mattress which was stained and dirty. At this inspection we found the mattress had been replaced with a wipe clean mattress and was clean. Arrangements were in place to manage infections. An infection control

lead was in place and carried out regular audits and room checks a copy of the annual infection statement for the last year which showed no infections in the past year. Staff had ready access to personal protective equipment (PPE), such as disposable gloves and aprons. Check sheets recorded all cleaning and had been completed as planned. The manager was unable to provide a copy of the risk assessment for infection control due to computer not working at the time of our inspection; however they confirmed that this had been completed.

At our previous inspection on the 13 July 2016 we found medicines were not managed safely. We told the provider they had to make improvements. At this inspection we found action had been taken and people received their medicines safely.

Staff told us they had received appropriate training and their competency to administer medicines had been assessed by the manager to ensure their practice was safe. Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Two staff checked each medicine was correct prior to taking it to the person. They then each initialled the MAR to confirm this had occurred and the person had received their medicine. Two people were prescribed medicine to be given four times per day and which should be given at least four hours apart. Care staff responsible for administering medicines described the procedure they used to ensure medicines were administered with an adequate gap between doses. Although not recorded the process used should ensure people received these safely.

The manager had introduced a daily and weekly stock checking system. This meant that any errors would be quickly identified and action could be taken to ensure the safety of the person. We undertook a stock check of boxed medicines and found the numbers held corresponded to the number of tablets that should be present. Formal medicines audits were not being completed. However, the manager informed us they were changing pharmacy and the new pharmacist was planning to complete a medicines management audit. Following this the manager intended to use the audit tool to undertake formal medicines audits. The provider had a medicines policy and procedure however, this had not been individualised to the home and therefore did not reflect the procedures used. For example, the policy described procedures for homely remedies which the manager said they did not use.

The manager was introducing new systems to ensure people's legal rights when taking medicines were protected however; these were not yet in place for all people. The manager informed us that although people would take tablets given to them, none of the people living at the home would be able to understand the reason for each medicine they were taking. They were therefore not giving informed consent. For one person a formal assessment of their ability to consent to medicines had been completed. This had been followed by a best interest decision showing that relevant people had agreed that it was in the person's best interest to receive the prescribed medicines. This protected the person's legal rights and followed best practice guidance. The manager stated they were planning to complete the same assessment and documentation for all other people living at the home.

Some people were prescribed 'as required' (PRN) medicines and had individual guidelines as to when these should be given however these guidelines were not in place for all people. The manager told us nobody would be able to say if they were in pain and required 'as required' medicines. We saw that people were receiving these. For example, one person had received 'as required' paracetamol as staff thought the person may have toothache. However, they did not have an individual plan in place to guide staff as to when to give as required medicines. The manager told us they were introducing 'as required' guidance forms for other people who may be prescribed as required medicines. This would help ensure people received these consistently and when required.

All medicines were stored securely and a refrigerator was available for the storage of medicines which required storing at a cooler temperature in accordance with the manufacturer's instructions. No medicines required to be kept cool at the time of the inspection. One person required a prescribed topical cream. This was stored securely in their bedroom meaning staff could access this when required. Staff were aware they should record the date of opening of prescribed topical creams. They had not done so in this case however, the pharmacy label showed the container would be within the safe to use timeframe. There was a medicine stock management system in place to ensure unnecessary medicines were not held and a process for the ordering of repeat prescriptions and return to the pharmacy of any unused medicines.