Sequence Care Limited

Oakdene House

Inspection report

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Ratings

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 16 March 2016 and took enforcement action. We served a warning notice in respect of a breach found of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This breach related to concerns regarding the safe management of people's medicines. People did not always received their medicines at the prescribed times and records relating to the administration of people's medicines had not always been accurately maintained.

We carried out this announced focused inspection on 27 July 2016 to check that the provider had met the requirements of the warning notice. The provider was given notice of the inspection shortly before our arrival on the day, to ensure minimal disruption to the daily routines of the people using the service.

At this inspection we looked at one aspect of the key question 'Is the service safe?' This report only covers our findings in relation to the focused inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Oakdene House' on our website at www.cqc.org.uk.

Oakdene House provides care and support for up to six people with learning disabilities, autistic spectrum disorder, mental health needs or sensory impairment. There were three people using the service at the time of our inspection. There was a new registered manager in post who had registered in the time since our previous inspection. 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.

At this inspection we found that the provider had met the requirements of the warning notice. People received their medicines as prescribed and records of the administration of people's medicines were accurate and up to date in all but one case. We have therefore amended the rating for the key question 'Is the service safe?' to 'Good'. The overall rating for the service remains 'Requires Improvement'. This is because we have yet to follow up on issues identified at our last inspection under the key questions 'Is the service effective?', and 'Is the service well-led?'

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

Action had been taken to improve safety at the service.

People's medicines were stored securely. People received their medicines as prescribed. Records relating to people's medicines were accurate and up to date in all but one case.

Oakdene House

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. We undertook an announced focused inspection of Oakdene House on 237July 2016. This inspection was done to check that improvements to meet required legal requirements after our 16 March 2016 inspection had been made. The inspector inspected the service against aspects of one the five questions we ask about services: 'Is the service safe?' This is because the service was not meeting legal requirements in response to part of that key question at the last inspection.

The inspection was undertaken by one inspector, and was announced. The provider was given notice of the inspection shortly before our arrival on the day to ensure minimal disruption to the daily routines of the people using the service. Before the inspection we reviewed the information we held about the home. This included notifications submitted by the provider. A notification is information about important events that the provider is required to send us by law. We used this information to inform our inspection planning.

During our inspection we spoke with the registered manager and two staff. We looked at records, including three people's medicines records and other records relating to the management of medicines within the service.

Good

Is the service safe?

Our findings

At our last inspection on 16 March 2016 we found a breach of regulations because people did not always receive their medicines at the prescribed times. We also found that records relating to the administration of people's medicines had not always been accurately maintained. This meant we were unable to determine whether people had consistently received the correct doses of their medicines as prescribed to them.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). We took enforcement action and served a warning notice on the provider and registered manager, requiring them to meet this regulation.

At this inspection on 27 July 2016 we found that improvements had been made to the way in which people's medicines had been recorded so that we were able to confirm people had received their doses correctly, as prescribed. We found that the requirements of the warning notice had been met.

People's MARs included a copy of their photograph, as well as details about any known allergies to help reduce the risks associated with the administration of medicines. We reviewed each person using the service's current MAR which contained up to date details of people's currently prescribed medicines. The completed records confirmed that people had received their medicines at the correct times each day when checked against remaining stock. We saw that additional checks were made on the stocks of boxed medicines through the use of countdown sheets, which were also completed upon administration to help ensure that each dose was accounted for.

We noted that one person's MAR had not been signed for the recent administration of a dose of an 'as required' medicine. However, despite this omission on the MAR itself, we found that the dose had been recorded as given on the back of the MAR and on the person's corresponding medicines countdown sheet, so we were able to confirm that the medicine had been administered appropriately. We also found that a box of one person's medicine, which had been dispensed by the pharmacist during the current medicines cycle, had not been recorded as received by the service, although we were again able to confirm that the remaining stock was reflective of the box having been received by reviewing the corresponding countdown sheet. Therefore there had been no issues with the administration of the medicine in question.

There had been no impact on people as a result of these minor issues; however the registered manager told us they would conduct a supervision session with the staff member who had not signed the MAR, and arrange for further training to ensure they were competent to administer people's medicines. We were unable to check on the outcome of this at the time of our inspection but will report on this next time we inspect.

Medicines were stored safely at the service. We saw that medicines were stored in locked cupboards within people's bedrooms or within a locked room at the service that only authorised staff had access to. Records showed that regular temperature checks of storage areas were conducted by staff. The registered manager confirmed they had taken action to reduce the temperature of one person's bedroom, where the

temperature had been found to slightly exceed the maximum recommended safe temperature for the storage of medicines, during the week prior to our inspection.

The provider had protocols in place for staff to follow with regard to people's 'as required' medicines. These provided information for staff on the doses and frequency at which such medicine could be administered, as well as guidance on the signs to look for which may mean administration was needed.

Staff responsible for administering medicines had received training and undergone an assessment of their competency for the role. Records also showed that regular audits had been conducted on the management of people's medicines and we saw that the registered manager had taken action to address any issues identified as a result of the audit process. For example, we saw more detailed instructions had been introduced with regards to an 'as required' medicine prescribed to one person, and that that records had been made of the opening of any liquid medicines or prescribed creams in response to recent audit findings.