DCS&D Limited

Heritage Healthcare - Darlington

Inspection report

Unit 1D Enterprise House
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Website: www.heritagehealthcare.co.uk

Date of inspection visit:
01 September 2016

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Ratings

Overall rating for this service	Good

Is the service safe?	Good

Summary of findings

Overall summary

This inspection visit took place on 1 September 2016. This was an unannounced inspection, which meant that the staff and provider did not know that we would be visiting. This was a follow up focussed inspection to look at issues we found on our visit to Heritage Healthcare on 23 and 24 March 2016.

When we visited the service on the 23 and 24 March 2016 we found that medicines were not administered in a consistently safe manner. There was a risk that people were not receiving their medicines as prescribed due to poor record keeping and auditing of errors.

We issued a requirement notice to the registered manager to send us a report (action plan), within 28 days, to explain how they intended to mitigate the risks of poor medicines management and address the breach of regulations. The registered manager sent this report to us promptly and we were satisfied with how they intended to address the issues we found.

Heritage Healthcare is a domiciliary care agency that provides personal care to people living at home within the Darlington area.

There is 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.
On this visit we spoke with the registered manager. They explained the checks they carried out to ensure medicines were administered correctly. We saw improvements the service had made around recording, administering medicines and the auditing system that was now in place.

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

The service was safe

We saw that medicines were administered, recorded and audited in a safe manner.

Heritage Healthcare - Darlington

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 (HCSA) and to review a breach of Regulation 12 in relation to medicines that we found on our visit to the home on 23, 24 March 2016.

This inspection took place on 1 September and was unannounced.

The membership of the inspection team was one adult social care inspector.

We reviewed all of the information we held about the service including statutory notifications we had received from the service. Notifications are changes, events or incidents that the provider is legally obliged to send us. We received no negative feedback from commissioners.

At our visit to the service we spoke with the registered manager.
During the inspection we looked at three peoples who used the service care files, Medicine administration record sheets (MARS) for three people, three peoples Medicine plans and risk assessments. We also looked at staff communication memos and staff meeting minutes.

Good

Is the service safe?

Our findings

We previously visited the service on 23 and 24 March 2016 and carried out a comprehensive rating inspection. We found that medicines were not administered and recorded in a consistently safe manner. There was a risk that people were not receiving their medicines as prescribed due to poor record keeping. During that inspection we were unable to observe medicines being administered in people's own homes but could see how medicines were managed and recorded.

We looked at the Medicines Administration Record (MAR) sheets. We found that one person's MAR sheet for eye drops wasn't signed for one full week. This meant there was no record to show if the medicine had been administered that week. When we asked the care co coordinator they told us that the MAR sheet hadn't made it out to the person's house from the office for that week period. We also found three missing signatures within two other people's MAR sheets for medicines prescribed for serious long term conditions. We saw that one person's cream was not signed for regularly in their MAR sheet. This meant that topical medicines were not administered and other prescribed medicines were not recorded correctly.

At the time of our comprehensive inspection the service were carrying out an audit of medicines and they were able to demonstrate to us how they managed the audit. We saw that that the audit for February 2016 MAR sheets was still on going and not completed. Within the audit we saw that errors had been identified but timely action was not taken. This meant that the service had not ensured the proper and safe management of medicines and had failed to do all that was practicable to mitigate risks to people.

This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the comprehensive inspection we issued a requirement notice to the registered manager to send us a report (action plan), within 28 days, on how they intend to mitigate the risks identified and address the breach in managing medicines safely. The registered manager sent this report to us promptly and we were satisfied with how they intended to address the issues we found.

On this focussed inspection we spoke with the registered manager. They showed us the medication administration records (MAR) for three people who used the service. Clear records were kept to show when people had their medicines. Body maps had been introduced for people receiving prescribed topical creams. This meant staff now had accurate information to help them identify where on a person's body topical creams needed to be applied, reducing the risk of errors.

We saw from looking at meeting minutes and staff communications that the registered manager had carried out discussions via team meetings and team memos to discuss the safe administration of medicines and to address the issues identified at our last inspection.

We were able to see from looking at three people's care records that an updated section had been added since our last inspection called 'my medication plan'. This section included an updated medicines risk

assessment to highlight any risks associated with administering or allergies.

The registered manager had developed a new monthly medication audit and told us; "The audits are now helping us to address any issues promptly. Now if there is a missing signature we monitor and bring the member of staff into the office and offer training or further action. We have made improvements to the MAR sheets for PRN (as and when required) medicines to make it clearer." We saw how this worked and how it had been made clearer for carers to follow. This showed us that action had been taken by the service to make improvements to the medicines administration system.