Sharda Care Limited

Victoria Care Centre

Inspection report

Acton Lane
Park Royal
London
NW10 7NS

Tel: 02089639780
Website: www.victoria-centre.co.uk

Date of inspection visit:
24 November 2016

Date of publication:
12 December 2016

Ratings

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on12 and 13 May 2016. At which a breach of legal requirements was found. This was because the provider did not always ensure the proper and safe management of people's medicines.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook an unannounced focused inspection on the 24 November 2016 to check they had followed their plan and to confirm that they now met legal requirements.

This report only covers our findings in relation to the safety topic area. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Victoria Care Centre on our website at www.cqc.org.uk.

At our last inspection in May 2016 we rated the service good and in the four topic areas; effective, caring, responsive and well-led and good as the overall rating. The service was rated requires improvement in the topic area safe.

Victoria Care Centre provides accommodation and personal and nursing care for up to 115 people some of whom may have dementia or physical disabilities. The home is purpose built and located in north west London. Public transport is accessible and there are shops within walking distance of the service.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission [CQC] 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 our focused inspection on the 24 November 2016, we found that the provider had followed their plan and legal requirements had been met. The provider had taken action to address our concerns about the way medicines were managed by the service. We found people's medicines were stored and managed safely so people were protected from unsafe treatment.

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

We found action had been taken to improve the safety of the service.

People's medicines were stored, managed and administered safely.

Victoria Care Centre

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 Victoria Care Centre on 24 November 2016 to check that the provider had made improvements to meet legal requirements after our inspection on 12 and 13 May 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 legal requirements in relation to that question.

The inspection was undertaken by one inspector. Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements.

During the inspection we spoke with eight people using the service, the registered manager, quality and compliance manager, two unit managers and five nurses.

We checked the systems in place for the management, storage and administration of people's medicines. We looked at 15 people's medicines administration records, nine people's medicines care plans,11 nurses' and senior care workers' medicines competency assessments, medicines audits and other records relating to the management of people's medicines.

Good

Is the service safe?

Our findings

At our comprehensive inspection on the 12 and 13 May 2016 we found that there were shortfalls in the management of people's medicines. There were gaps on some people's medicine administration records indicating that some people may not have had their medicines as prescribed and therefore their health could have been put at risk. Also we found there were no individual protocols to enable nurses and senior care workers who administered medicines to know in what circumstances and when medicines should be given when prescribed as required [prn]. The medicines policy did not include procedures for managing people's medicines when they were prescribed as required, and when they went home on leave, so staff administering medicines did not have all the guidance they needed to manage medicines appropriately and safely.

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

At our focused inspection 24 November 2016 we found that the provider had followed the action plan they had completed to meet shortfalls in relation to the requirements of Regulation 12 described above.

People told us they received the medicines they were prescribed on time. A person told us "I get my medicines on time. They [staff] are very conscientious." A written compliment from a person's relative included "I thank the staff for being aware of [Person's] special needs especially administration by nursing staff the medication [Person] needs, in liquid form."

We viewed the systems in place for the management and administration of medicines including Controlled Drugs [CDs, prescription medicines that are controlled under the Misuse of Drugs legislation] in all four units of the service. We found people had their prescribed medicines recorded on their Medicines Administration Records [MARs] and there were no gaps in the MARs that we looked at which indicated people received the medicines they had been prescribed. We also found that there were individual protocols for administering medicines prescribed to be given to people as required [prn] were in place. These included protocols for the administration of prn pain relieving medicines, and prn medicines to be given when a person had a seizure.

The medicines policy had recently been reviewed and updated and was found to include procedures for managing people's medicines when they were prescribed as required, and when they went home on leave, so staff had the guidance they needed to administer medicines safely.

We found records of three peoples' stock of a prn medicine had been incorrectly documented during nightly stock checks of medicines by staff. When we checked these medicines we found the actual stock of prn medicines was correct which showed people had received the medicines they had been prescribed so there had been no risk to their health. The quality and compliance manager told us she would investigate the matter, and she took prompt action directing staff to check all stock medicine. She also developed during the inspection an improved record of daily medicines stock checks for staff to complete to minimise inaccurate recording. She told us following the inspection that the new record form and improved daily

checks of medicines was implemented on all units during the evening of the day we inspected the service.

We saw medicines being administered to people in a positive manner. Nurses administering medicines engaged with people in a pleasant way. They explained what they were doing and waited until people had swallowed their medicines before signing the MAR and before administering medicines to the next person. A nurse administering medicines asked people if they had any pain and administered pain relieving medicine when this was required. We noted nurses administering medicines always locked the medicines trolley when they were away from it so medicines were stored safely at all times.

On each unit medicines were stored in a locked room specifically used for the safekeeping of medicines. The temperature of the medicines storage rooms and the medicines fridges were monitored closely to ensure they were stored at a temperature that maintained their effectiveness. CDs were stored in separate locked medicines cabinets. We found they were managed safely.

People's medicines care plans were reviewed regularly and included assessment and details of each person's individual medicine needs including whether they liked to take their medicines with a drink. People's care plans included information about staff asking for people's consent before administering medicines. We saw a decision had been made to give a person prescribed medicines in their best interest when the person had been unable to make a decision about their medicines. Medicines audits included checks of people's medicines' care plans to make sure they were up to date and included appropriate information about people's medicines needs.

The nurses we spoke with all told us they had received a medicine competency assessment to check they were fit to manage and administer people's medicines safely. Records confirmed that nurses and senior healthcare assistants had received medicines competency assessments and had their competency to manage medicines reviewed regularly. We found appropriate action had been taken when a member of staff had not signed two people's MARs after administering their medicines. The member of staff met with their supervisor, the issue discussed, further medicines training planned and close monitoring of their performance commenced. A risk assessment was in place for a person who was at risk of choking and a protocol within the risk assessment included guidance about administering the person one medicine at a time to minimise choking.

Medicine incidents were responded to appropriately. For example a comprehensive investigation had taken place when a member of staff had signed a person's MAR when a medicine had not been administered. The GP and local authority had been informed. Records showed that reflection and learning had taken place in response to the incident.

Checks of the medicines were carried out. These included daily checks of the MARs were carried out to check people had received the medicines they were prescribed. Weekly and monthly checks of the management and administration of medicines on each unit were also carried out. We saw that action had been taken to address shortfalls found such as developing a pain care plan and a protocol for administering as required pain relieving medicine for a person using the service.

The registered manager told us that as part of the monitoring of the service medicines were discussed and reviewed during the monthly quality governance meeting. He told us that improvements had been made to ensure there was consistency of practice regarding the management and administration of medicines on each unit. He told us where examples of good practice had been found in one unit such as the use of a particular medicines record this had been shared and was now used in other units.