Autism Initiatives (UK)

Outreach Services

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 16 and 23 January 2015 when we found a breach of legal requirements. The breach of regulations was because we had some concerns about the way medicines were managed and administered within the service.

We asked the provider to take action to address these concerns.

After the comprehensive inspection, the provider wrote to us to tell us what they would do to meet legal requirements in relation to medication management.

We undertook a focused inspection on 29 September 2015 to check that they had now met legal requirements. This report only covers our findings in relation to this specific area / breach of regulations. As such the report only covers the key question 'Is the service safe? This is one of the five key questions we normally inspect; the others being, 'Is the service effective', 'Is the service responsive', 'Is the service caring' and 'is the service well led'

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Outreach Services' on our website at www.cqc.org.uk.

The Outreach Service provides domiciliary care and support for people with learning disabilities who live in the community. Some people are supported in tenanted accommodation and others are supported at home with their parents and family. The agency is owned by Autism Initiatives who provide a network of support services for people with learning disabilities.

On this inspection we found that improvements had been made and that medicines were being administered safely. We had discussions with the staff about how further improvements could be made around some areas of good practice.

We found good examples where people had been encouraged and supervised to manage their own medication in a safe way so that their independence was respected.

Other medicines we reviewed were stored safely and were locked away securely to ensure that they were not misused.

Summary of findings

We asked about people who were on PRN [give when needed] medication; for example for pain relief. We found clear care plans had been drawn up to include supportive information for these medicines. The importance of a PRN care plan is that it supports consistent administration and on-going review.

There were no people being supported to take medicines 'covertly' [without their knowledge in their best interest]. We saw, however, that the services medication policy made reference to this and covered areas of best practice including reference to people's rights under the Mental Capacity Act 2005.

We reviewed one person who was being treated with a medication supplied by the Community Mental Health Team [CMHT] and was being monitored by them. The service liaised with the CMHT to support the person.

Staff we spoke with were knowledgeable regarding the medicines administered to people. Staff told us they undergo training to ensure they are safe to administer medicines. On this inspection we saw three staff files which contained a record showing staff had been directly observed by senior staff and recorded as competent and safe. This was an improvement.

We asked about medication audits / checks carried out by senior staff or managers. We were told that there are two regular audits carried out. The first was a weekly check made by care staff and included a stock check of medicines. This basic audit was supported by a senior management audit carried out at intervals by a manager responsible for overseeing medication policy.

Although we found improvements overall, there were anomalies with recording of medications which meant it was difficult to carry out an audit of medicine stock at the time of the inspection.

We discussed how best practice around recording could be achieved by ensuring the medication administration record [MAR] chart was used as the central recording of all medicines received, carried forward and administered. This would help ensure an easier and more accurate auditing process.

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?

The service was safe.

Improvements had been made and medicines were administered safely.

We made recommendations to further develop medication administration records [MARs] in line with best practice.

While improvements had been made we have not revised the rating for this key question. To improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for 'safe' at the next comprehensive inspection.

Requires improvement

Outreach Services

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 checked 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 this focused inspection on 29 September 2015. The inspection was completed to check that improvements to meet legal requirements identified after our comprehensive inspection on 16 & 23 January had been made. 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 this question.

The inspection team consisted of an adult social care inspector.

During the visit we were able to speak with one of the people who was being supported by the Outreach service.

We spoke with three staff members including senior managers for the organisation. We looked at the care and medication records for four of the people being supported. We also looked at supporting policies and audits carried out to support safe medication administration.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of the service in January 2015 we had some concerns about the way medicines were managed and administered. We asked the provider to take action to address these concerns. Following the inspection we were sent an action plan from the provider which told us how the service was going meet requirements and ensure safe administration of medicines.

On this inspection we found that improvements had been made and that medicines were being administered safely. We had discussions with the staff how further improvements could be made around some areas of good practice.

We found good examples were people had been encouraged and supervised to manage their own medication in a safe way so that their independence was respected. We spoke with one person who was managing their own medicines who told us they felt well supported by staff. They told us they understood when to take their medicines and showed us how they recorded this so that staff could monitor how they were managing. They told us they had daily discussion and support from staff. We looked at the care records supporting this practice and saw supporting care plans and documentation. We saw that the person's medication management was regularly reviewed. We saw the care 'protocol' [plan] in place in the person's room had not been updated, however, and did not refer to current practice. Staff told us they would update this.

Other medicines we reviewed were stored safely and were locked away securely to ensure that they were not misused. Four people who were more dependent and required staff to administer medicines had separate locked cabinets with their individual medicines in them. Each cabinet had a current list of medicines for each person on the door and a photograph of the person concerned. This helped staff to identify each individual person and helped reduce the risk of any errors occurring.

We asked about people who were on PRN [give when needed] medication; for example for pain relief. We found clear care plans had been draw up to include supportive information for these medicines. The importance of a PRN care plan is that it supports consistent administration and on-going review. There was also an additional protocol in place so that care staff were required to refer any decision to administer PRN medication to a senior manager on call. This helped ensure thorough monitoring of PRN medication. We also saw a person who was prescribed an external topical medication [cream] had a supporting care plan. This was an improvement from the previous inspection.

There were no people being supported to take medicines 'covertly' [without their knowledge in their best interest]. We saw, however, that the services medication policy made reference to this and covered areas of best practice including reference to people's rights under the Mental Capacity Act 2005. Staff and managers displayed appropriate knowledge regarding this.

We reviewed one person who was being treated with a medication supplied by the Community Mental Health Team [CMHT] and was being monitored by them. The person concerned needed to undergo regular blood monitoring to ensure the therapeutic safe levels for the medicine. We saw good supporting information and plans around this. The service liaised with the CMHT to support the person. The medicine was stored following the CMHT protocol and was regularly checked by two staff.

We saw handwritten medicines for one person on their medication records. We saw that the staff member completing the record had signed the entry and this had been witnessed by a second staff member. The need to ensure two staff checked and signed the record was to reduce the risk of an error occurring. This was an improvement from our previous inspection.

Staff we spoke with were knowledgeable regarding the medicines administered to people. Staff told us they undergo training to ensure they are safe to administer medicines. At our previous inspection we were told by staff they were formally assessed to ensure their 'competence' by senior staff following the initial training. We had found no supporting records of this however. On this inspection we saw three staff files which contained a record showing staff had been directly observed by senior staff and recorded as competent and safe.

We asked about medication audits / checks carried out by senior staff or managers. We were told that there are two regular audits carried out. The first was a weekly check made by care staff and included a stock check of

Requires improvement

Is the service safe?

medicines. This basic audit was supported by a senior management audit carried out at intervals by a manager responsible for overseeing medication policy. The last one of these was carried out on 23 June 2015.

When we looked at medication records to see whether medication had been administered by staff we saw two staff had signed to say they had administered the medication. This helped ensure errors were reduced. The service had clear protocols for reporting any medication errors. There had been a minor error recorded on one occasion recently and this had been appropriately followed up by managers so that any lessons could be learnt.

Although we found improvements overall there were anomalies with recording of medications which mean't it was difficult to carry out an audit of medicine stock at the time of the inspection. The individual medication administration records [MAR's] did not have a record of the quantity or date when medicines had been received. We were shown a separate record of how each person's medicines were received into the service and this was used when carrying out weekly audits. When we used these records to determine the stock of one of the medicines [medicines received and weekly audit check] we found the dates recorded when the medicine had been received were different. This meant it was not easy to carry out an effective check.

We discussed how best practice around recording could be achieved by ensuring the MAR chart was used as the central recording of all medicines received, carried forward and administered. This would help ensure an easier and more accurate auditing process.

We recommend that further developments are made with reference to current best practice guidance issued regarding recording medication administration.