

Hillgreen Care Limited

Hillgreen Care Limited - 14 Colne Road

Inspection report

14 Colne Road
London
N21 2JD

Website: www.hillgreen.co.uk

Date of inspection visit:
07 March 2016

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19 April 2016

Ratings

Overall rating for this service

Inadequate ●

Is the service safe?

Inadequate ●

Summary of findings

Overall summary

This focused inspection took place on 7 March 2016 and was unannounced. This inspection was carried out by a single inspector. We undertook this inspection because we had concerns about the safe management of epilepsy for people using the service. This report only covers our findings in relation to the management of risk and medicines within the safe section. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hillgreen Care – 14 Colne Road on our website at www.cqc.org.uk

14 Colne Road is a residential care home providing care for up to six younger adults with learning disabilities. On the day of the inspection there were three people using the service.

Protocols to keep people safe in the event of an epileptic seizure were not always being followed which was putting people at risk of unnecessary and, potentially, significant harm.

Staff had not been provided with specific training in the use of an emergency epileptic medicine so this potentially lifesaving drug could not be administered if required.

During this inspection we found the provider to be in breach of Regulation 12 (1)(2)(a)(b)(g) in relation to assessing risk and the safe management of medicines.

This report only covers our findings in relation to these breaches. We are in the process of taking enforcement action against the provider.

We will undertake another unannounced inspection to check on all other outstanding breaches of regulations identified for this service.

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 not safe as protocols to reduce the harm of epileptic seizures were not always being followed and an important medicine to combat the negative effects of an epileptic seizure was not available, if required, in an emergency.

Inadequate ●

Hillgreen Care Limited - 14 Colne 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. 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.

This focused inspection took place on 7 March 2016 and was unannounced. This inspection was carried out by a single inspector. Prior to the inspection we spoke with the local authority and one relative of a person who used the service.

On the day of the inspection we spoke with two people who used the service and three staff members who were on duty at the home. We looked at two people's support plans which included risk assessments and other information regarding their health needs. We checked medicine records and staff training records. After the inspection we requested other training documents from the provider.

Is the service safe?

Our findings

Staff told us and records confirmed that there were two people currently using the service who were living with epilepsy. We looked at one person's support plan which included a record of the number of seizures they had suffered and the duration of each seizure. Their epilepsy protocol, within their support plan, described the action staff must take when a seizure occurred. This included keeping the person safe and calling an ambulance each and every time a seizure occurred regardless of the duration. All three staff we spoke with were aware of this protocol and said they always called out an ambulance if the person was having a seizure.

After each seizure, staff completed an incident form detailing what had happened and how the person was recovering and what first aid was administered. We looked at records of this person's seizures and saw that this current year an ambulance had been called out after each seizure. However, in September and October last year we identified two occasions when an ambulance had not been called out after the person had suffered a seizure even though, on one of these occasions, the person had sustained a head injury. Staff could not tell us why the epilepsy protocol had not been followed but did say that the manager or deputy manager had been informed.

We looked at the support plan for the other person with epilepsy and found two protocols with conflicting advice and information about what to do in the event of a seizure. One document entitled 'epilepsy guidelines' did not have the name of the person on it or any dates of potential reviews. This document advised staff to call out an ambulance after each time a seizure occurred. We spoke with staff about this and they said this was not the guidance they were aware of and that they had never called out an ambulance as this person's seizures were generally mild and did not cause them any concerns.

The second epilepsy protocol in this person's support plan had a fax date of November 2011. There was no evidence that this plan had been reviewed. This protocol stated that an ambulance must only be called out if the seizure lasted more than five minutes, staff had any concerns about the person or if the person suffered two seizures in a short space of time. This protocol also included the use of an epilepsy medicine that needed to be used in an emergency. Staff told us they did not use this medicine and did not know where this medicine was located.

People using the service were being put at unnecessary risk because protocols were not always being followed and there was no record of why staff had not followed them. Protocols also contained conflicting information for staff regarding what to do in the event of a seizure.

This was in breach of Regulation 12 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at records in relation to people's healthcare appointments. We saw that one person had seen their GP in July 2015 for an epilepsy review. We also spoke with the staff member who had taken the person for the review. The records showed and the staff member confirmed that the GP had prescribed Buccal

Midazolam, which was the epilepsy medicine detailed in the person's epilepsy protocol for use in emergencies. This protocol stated that the medicine must be used if the person's seizure lasted more than five minutes or if there were two recurrent seizures, one after the other. However, this medicine could not be located in the medicines cupboard and was eventually found by staff in an adjacent store room.

Although this medicine was available at the home, it was not stored in a place where everyone would know where it was or be able to access it quickly in an emergency. Buccal Midazolam is a schedule 3 Controlled Drug (CD) and although it doesn't need to be stored in a Controlled Drug cupboard, or recorded in the Controlled Drug register, it is good practice to do this. This medicine should be stored safely and securely.

Due to the potential dangers of this medicine, anyone who administers it must have completed specific training in its safe use and administration. Staff told us they had not received this training and therefore did not know how to use it safely. We noted that this person had not experienced a seizure that had lasted more than five minutes since 2014. However, this medicine had been prescribed for use in emergencies and staff would not be able to use it which put the person at risk of serious harm.

This was in breach of Regulation 12 (1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns regarding this medicine and the deputy manager told us they would ensure a GP reviewed this person's epilepsy protocols as a matter of urgency as well as request training in the use of Buccal Midazolam from the provider.