The Drive Care Homes Limited

The Drive

Inspection report

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Ratings

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

Summary of findings

Overall summary

This inspection took place on 27 February 2017 and was unannounced. The Drive is a care home which provides accommodation and support for up to twelve people with learning and physical disabilities. There were nine people using the service at the time of our inspection.

We carried out an unannounced comprehensive inspection of this service 27 September 2016 at which a breach of a legal requirement was found. We found that people's medicines were not being managed safely. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the management of medicines at the home.

The home did not have 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. The current manager had begun the process of applying to the CQC to become the registered manager for the home.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to that requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'The Drive' on our website at www.cqc.org.uk.

We found that the provider had addressed the breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). There were safe systems in place for storing, administering and monitoring medicines at the home. We found that medicines were managed appropriately and people were receiving their medicines as prescribed by health care professionals.

We could not improve the rating for 'safe' from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

We found that action had been taken to improve safety

Medicines were managed appropriately and people received their medicines as prescribed by health care professionals.

We could not improve the rating for 'safe' from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

The Drive

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook a focused inspection of The Drive. This inspection was completed to check if improvements had been made to meet the legal requirements for the breach to regulations we found after our comprehensive inspection 27 September 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 because people's medicines were not managed safely.

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. We looked at the medicines records of six people who used the service. We also spoke with the registered provider, the home manager and two members of staff about how medicines were managed at the home.

Requires Improvement

Is the service safe?

Our findings

At our inspection on 27 September 2016 we found that people's medicines were not being managed safely. We found that staff undertook regular temperature checks of storage areas. However the temperature checks recorded in one month showed that there had been three occasions when the temperature had slightly exceeded the maximum safe temperature for the storage of medicines. The form used to record the temperature checks had not been completed to indicate that any action had been taken to address these high temperatures at the time and a staff member we spoke with was not aware of the maximum safe temperature for medicines storage. This meant people were at risk of receiving medicines which were unsafe or ineffective because staff were not always aware of the need to take action where safe temperatures had been exceeded. We also found that people's Medicines Administration Records (MARs) had been completed by staff to confirm that people had correctly received their medicines at the prescribed times. However one person had received a dose of some of their medicines twice during one day. This misadministration had not been recorded on the persons MAR, placing them at risk should a healthcare professional need to review this information in an emergency.

The provider sent us an action plan on 14 November 2016 telling us how they planned to improve how medicines were managed at the home.

At this inspection on 27 February 2017 we looked at medicines were being managed at the home.

Medicines were administered safely. The manager told us and records confirmed that only trained staff administered medicines to people using the service. We saw medicines competency assessments had been completed by these staff before they could administer medicines. We observed one member of staff administer medicines to people safely in a caring and unrushed manner. We saw that people's Medicines Administration Records (MARs) were clearly set out and easy to follow. They included their photographs, details of their GP, information about their health conditions and any allergies. As required medicines (PRN) were recorded on MAR's and signed for by staff when administered. We observed the member of staff administering medicines asking people if they needed their PRN medicines for example, checking if they were in any pain. There was individual guidance in place for staff on when to offer people PRN medicines.

Medicines were stored securely in a locked medicines trolley that was kept in a secure medicines storeroom. We checked the balances of medicines stored in the medicines trolley for six people against the MAR and found these records were up to date and accurate. The records indicated that people were receiving their medicines as prescribed by health care professionals. There were safe systems for monitoring of controlled drugs. Checks of controlled drugs were in place and were recorded in a controlled drugs book. The home had a safe system for the disposal of medicines. We saw records of returned medicines had been signed as received and dated by the dispensing pharmacist.

At the last inspection the manager told us they would discuss the monitoring of the temperature of the storage area with staff at an upcoming staff meeting. At this inspection we saw minutes from a staff meeting held in September 2016 where discussions took place in respect of staff responsibilities for reporting

medicines errors and the accurate recording of the medicines storage room and fridge temperatures and the actions that staff should take should issues occur. The manager showed us a form for recording medicines administrations errors and told us these would be completed in the event of a medicines error and stored in people MAR's and care folders. Staff we spoke with were aware of the need to report and record any medicines administrations errors and store the documents in peoples MAR's and care folders. We saw that daily medicines fridge and medicines room temperature monitoring was in place and recordings were within the appropriate range. The manager and two staff we spoke with were aware of the minimum and maximum safe temperatures for medicines storage. Regular daily counts and weekly audits of medicines were completed by staff and the manager to monitor and reduce the likelihood of any risk. These processes helped protect people from the risks associated with inappropriate use and management of medicines.

We found that the provider had addressed the breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). We could not improve the rating for 'safe' from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.