

Vijaykoomar Kowlessur

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## Inspection report

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28 July 2017

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## Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service well-led?

Good ●

# Summary of findings

## Overall summary

At our previous inspection of this service on 22 and 23 May 2017, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation relates to the safe management of medicines. Due to the seriousness of the concerns found we issued a warning notice to the provider and registered manager on 19 June 2017, requiring compliance with the Regulation by 5 July 2017.

In addition, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as a result of poor management oversight of medicines management and ineffective auditing processes. For this breach, we issued a requirement notice requesting that the registered provider submit an action plan to address the concerns. The action plan was submitted on 19 July 2017. On this inspection, we checked whether the registered manager and provider had completed the actions as identified on the action plan.

This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Vijaykoomar Kowlessur on our website at [www.cqc.org.uk](http://www.cqc.org.uk)

A registered manager was in place. 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.

At this inspection we found that significant improvements had been made to how the service ensured safe medicines management. We found that medicines stocks balanced with what medicines administration records (MARs) stated and medicines were stored safely and securely. With the exception of one administration of medicine, we saw that the administration of medicines was documented appropriately.

Measures were now in place to ensure that stock balances of 'as required' medicines were recorded accurately which was regularly checked by the registered manager as part of the auditing process in place.

The service had met the requirements and regulation identified in the warning notice.

## 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 now safe. The provider had made significant improvements to how they managed medicines. They were now safely stored, administered and documented.

Good ●

### Is the service well-led?

The service was now well led. There were quality assurance systems in place to ensure that medicines were managed safely.

The registered manager had increased oversight of medicines management.

Good ●

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## **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 28 July 2017 and was unannounced. We inspected the service against two of the five questions we ask about services: is the service safe and is the service well-led. This is because the service was not meeting some requirements. The inspection was carried out by a single inspector.

Prior to the inspection we reviewed the previous inspection report, warning notice and action plan submitted by the registered manager.

During the inspection we looked in detail at records relating to the safe management of medicines at the service. We looked at records relating to medicines administration for four people, medicines audits, training records, pharmacy returns book and stock monitoring records in relation to medicines management and how medicines were stored. We spoke with the Registered Manager and one staff member.

## Is the service safe?

### Our findings

At our last inspection of the service on 22 and 23 May 2017, we found that the provider was in breach of the regulation relating to medicines management. We found that some medicines were not stored safely. People's Medicine Administration Records (MARs) were not always completed in full or accurately. Quantities of high risk 'As required' medicines were not routinely monitored and stock balances did not correspond with recorded administrations on MARs. We issued a warning notice to the provider and registered manager on 19 June 2017, requiring compliance with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 5 July 2017.

At this inspection we found that the provider had made significant improvements to address the concerns identified with medicines at our last inspection. We checked MARs records for the months of June and July 2017 for the four people prescribed medicines at the service.

Medicines received from the pharmacy were recorded on the MAR charts and the quantities confirmed on inspection could be reconciled with the administration records which were clear and accurately documented. MARs were completed accurately without any gaps in recording. We checked the medicines returns records which clearly detailed medicines that were returned to the pharmacy on a monthly basis. Medicines returned corresponded to the quantities recorded on MARs.

Medicines were stored safely and securely in a locked medicines cabinet in the living room. Storage temperatures were recorded on a daily basis and were documented as being within an accepted temperature range.

Some medicines taken as needed or as required are known as 'PRN' medicines. Some people were prescribed PRN medicines for pain relief. Other PRN medicines such as Lorazepam and Diazepam are prescribed to reduce anxiety and agitation. At our previous inspection, we found significant quantities of PRN medicines unaccounted for. At this inspection we found that PRN medicines were counted and double-checked on a daily basis. Staff were now recording the balance on an on-going basis on the person's MAR after each administration. A staff member told us that they were committed to maintaining the improvements made to the management of medicines at the service.

When PRN medicines were administered, staff were recording the reasons why and the effect the medicine had on the person on a separate PRN chart. We found one instance of where a staff member did not complete the PRN chart three days prior to the inspection, however we saw that they had signed the person's MAR and we saw that they communicated with the registered manager via text message to advise that they were administering PRN medicine to the person. PRN protocols were in place for every person who had been prescribed PRN medicines which gave staff guidance on the steps to take prior to administering PRN medicines.

Body maps and topical MAR were also in use in the service and these detailed where creams should be applied.

Following the last inspection, all staff administering medicines underwent medicines training which was delivered by the services pharmacy supplier.

## Is the service well-led?

### Our findings

At our last inspection on 22 and 23 May 2017, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered manager and provider's quality assurance systems were ineffective regarding medicines management. The registered manager completed a monthly audit of the service, however medicines stocks were not counted and cross referenced with MAR's during the audit, despite the audit confirming PRN medicines were stock checked.

At this inspection, the provider had addressed this issue. We checked the registered manager's monthly audit for May and June 2017 which confirmed that 'medication was checked, stocked counted and signatures checked.'

A daily PRN medicines stock check was developed which required staff to count all PRN medicines on a daily basis. Balances of stocks against records were checked by two staff members. The registered manager checked the stock on at least a weekly basis and again when medicines were prepared to be returned to the pharmacy.