Anchor Carehomes Limited

Bloomfield Court

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

Bloomfield Court provides care and support for up to 47 people who may live with dementia and conditions related to old age. At the time of our inspection 47 people lived at the home.

We carried out a focussed inspection on 27 June 2017 to follow up on concerns in relation to medicines management. We found that improvements had not been made and there was a continued breach in relation to Regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to unsafe medicine management. We issued a warning notice and the provider wrote to us to say what they would do to meet the legal requirements.

We carried out an unannounced focussed inspection of this service on 26 September 2017.
We undertook this focused inspection to check that the provider had followed their plan and to confirm that they now met legal requirements. 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 Bloomfield Court on our website at www.cqc.org.uk

The home had a registered manager who was not present at our inspection. 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.

We found that overall medicines were managed safely and people received their medicines as prescribed.

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 the management of medicines.

The provider has made improvements in respect of medicines management so that people are better protected from any risks associated with this activity.

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

Bloomfield Court

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.

The inspection was carried out by a member of the medicines optimisation team. We undertook an unannounced focused inspection of Bloomfield Court on 26 September 2017. This inspection was done to check that improvements to meet the warning notice after our focussed inspection of 27 June 2017 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 some legal requirements in respect of medicines management.

We spoke with one person who lived at the home, the deputy manager, one team leader and one senior carer. We checked Medicine Administration Records (MAR) for 10 people in detail but also looked through all 47 MAR charts for every person in the home.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in June 2017 we found that the provider continued to be in breach of the law as medicines were not managed safely.

At this inspection, people's medicines were available to give to treat their diagnosed health conditions at the time of the inspection. However, there continues to be an on-going issue with electronic prescriptions not being sent between the GP surgery and the supplying pharmacy. This is not within the control of the service; however the registered manager continues to have discussions with the GP surgery and the pharmacy to reduce the impact on people.

Medicine Administration Records (MAR) charts documented that people had been given their prescribed medicines. We observed a senior carer administering a time critical medicine for one person at midday. They understood the importance of ensuring the person had their medicine at a specific time. This was undertaken following safe practice to ensure the correct medicine was administered and recorded on the person's MAR chart.

Arrangements were in place for accurate medicine stock checks. All the balances we checked were accurate. This meant that records and checks documented that people were being given their prescribed medicines.

Supporting information for staff to safely administer medicines was available and easily accessible. There was clear documentation for the site of applying skin preparations on a person's body. When people were prescribed a medicine to be given 'when required' we found that person centred information was available to enable staff to make a decision as to when to safely give the medicine.

Any changes or additions made to people's medicines by a doctor were recorded and kept together with their MAR charts. This information was very helpful for staff to quickly check that the correct medicine and dose was being administered.

Arrangements were in place to ensure that medicines with a short expiry were dated when they were opened.

Medicine storage was secure with access only by authorised members of staff.

The service was undertaking regular medicine audits and any issues with medicines were being identified. We were shown examples of learning from these audits and what lessons were learnt to prevent them happening again. Staff had undertaken an online training system on safe medicine management and handling.