Bramble Lodge Care Home Limited

The Grove and The Courtyard

Inspection report

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Ratings

Is the service safe?

Overall summary

We carried out an unannounced comprehensive inspection of the service on 4 and 9 December 2014. After this inspection we received safeguarding concerns in relation to the management of medicines. The local authority had put a block on admissions because of medicine concerns on two units. However, the Care Quality Commission was informed prior to this inspection that this block had been lifted.

The Grove and The Courtyard is a purpose built care home providing care for different client groups across four separate units. The Lodge accommodates a maximum number of 14 people living with a dementia and who have nursing needs. The Cleveland unit can accommodate a maximum number of 14 people with mental health conditions. Courtyard unit on the ground floor can accommodate 12 people and Courtyard unit on the first floor can accommodate 15 people with mental health conditions. Accommodation is provided over two floors and includes communal lounge and dining areas. Externally there are garden areas and a car park.

The service had a registered manager. 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 carried out this inspection on 23 April 2015.This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting.

During our inspection we looked at the arrangements for the management of medicines. There had been concerns previously about delays in obtaining some medicines which meant that people had been unable to take these medicines as prescribed. We saw that improvements had been made in the ordering process for repeat medicines to address this issue.

Appropriate arrangements were in place in relation to the recording of medicines. There was a process in place for monitoring these records regularly to check that they were completed properly. However, we saw that records for the application of creams and ointments by care staff were not fully completed and it was not always possible to confirm that they had been offered to people, or applied regularly.

Summary of findings

People told us they received all their prescribed medication on time and when they needed it. We observed medication being administered to people safely. People wanting to self-administer medicines were supported to do so. However, we recommend that the service consider the current guidance on risk assessments for people who self- administer medicines and take action to update their practice accordingly.

We looked at the guidance information kept about medicines to be administered 'when required'. Although there were arrangements for recording this information we found this was not kept up to date and information was missing for some medicines. This meant there was a risk that care staff did not have enough information about what medicines were prescribed for and how to safely administer them.

We looked at care plans for five people with complex healthcare needs for example diabetes. We saw that guidance for the use of prescribed medicines was not always clear. This meant that care staff did not have sufficient information to safely manage people's medical conditions.

Medicines were kept securely. Records were kept of room and fridge temperatures to ensure they were safely kept.

Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. We found that whilst the provider had completed a medicine audit recently the discrepancies that we found had not been identified.

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, but some improvements were required.

Systems were in place for the management of medicines so that people received their medicines safely. However risk assessments were missing for two people who managed some of their own medicines. Records for the application of creams were incomplete and care plans for people with medicines prescribed when required or for people with complex health needs were not sufficiently detailed.

The Grove and The Courtyard

Detailed findings

Background to this inspection

We undertook an unannounced focussed inspection of the Grove and the Courtyard on 23 April 2015. We received safeguarding concerns in relation to the management of medicines. The local authority had put a block on admissions because of medicine concerns on two units. However, the Care Quality Commission was informed prior to this inspection that this block had been lifted.

The inspection team consisted of one pharmacist inspector. We inspected the service against one of the five questions we ask about services: Is the service safe. Before this inspection we reviewed all of the information we held about the service. During the inspection we spoke with the registered manager, deputy manager, the regional support manager, two nurses and two care staff. We also spoke with two people who used the service.

Is the service safe?

Our findings

During our inspection we looked at the arrangements for the management of medicines. There had been concerns previously about delays in obtaining some medicines, so people had been unable to take these medicines as prescribed. Staff told us of improvements made to the ordering process for repeat medicines to address this issue.

Appropriate arrangements were in place in relation to the recording of medicines. There was a process in place for monitoring these records regularly to check that they were completed properly. We saw that action had been taken to follow up and resolve any discrepancies which had been identified during these checks. However, we saw that records for the application of creams and ointments by care staff were not fully completed and it was not always possible to confirm that they had been offered to people, or applied regularly.

People told us they received all their prescribed medication on time and when they needed it. We observed medication being administered to people safely. People wishing to self-administer medicines were supported to do so. However, we recommend that the service consider the current guidance on risk assessments for people who self-administer medicines and take action to update their practice accordingly.

We looked at the guidance information kept about medicines to be administered 'when required'. Although there were arrangements for recording this information we found this was not kept up to date and information was missing for some medicines. This meant there was a risk that care staff did not have enough information about what medicines were prescribed for and how to safely administer them. For example the when 'required guidance' had not been updated when the prescribed medicine was changed. For another person the prescribed dose had changed but the 'when required' guidance had not been updated to reflect this.

We looked at care plans for five people with complex healthcare needs for example diabetes. We saw that guidance for the use of prescribed medicines was not always clear. This meant that care staff did not have sufficient information to safely manage people's medical conditions.

Medicines were kept securely. Records were kept of room and fridge temperatures to ensure they were safely kept. Air conditioning units were now in place in the treatment rooms which had been above the recommended temperature for the safe storage of medicines at a previous visit. The room used for storage of medicines in the Courtyard was now no longer used as a hairdressing room and was used only for the storage of medicines and care plans.

Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss.

We looked at how medicines were monitored and checked by managers to make sure they were being handled properly and that systems were safe. We found that whilst the provider had completed a medicine audit recently the discrepancies that we found had not been identified.