Festival Care Homes Ltd

Barleycroft Care Home

Inspection report

Spring Gardens
Romford
Essex
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Ratings

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

Overall summary

When we visited this service on 18 and 19 March 2014 we found that the provider was in breach of the regulation that related to medicines. People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. The provider sent us an action plan stating the steps they would take to address the issues identified.

We carried out an unannounced comprehensive inspection of this service on 15 and 16 October 2014 at which we found that this breach of legal requirements had still not been met. This was because the systems in place for the administration of medicines were not safe. Some people had not received all their medicines as prescribed which, was a risk to their health and welfare. Concerns identified in medicines audits were not responded to and there was no guidance for staff for the administration of medicines that were prescribed on an 'as required' basis or that should only be given under specific circumstances.

As a result of this we took enforcement action against the provider and a warning notice was served under Section 29 of the Health and Social Care Act 2008. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the warning notice and breach of regulations. We undertook a focused inspection on the 24 April 2015 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 this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Barleycroft Care Home on our website at www.cqc.org.uk.

Barleycroft is a purpose built 80 bed care home providing accommodation and nursing care for older people, including people living with dementia. There are three separate units. The first provides residential care, the second dementia nursing care and the third general

Summary of findings

nursing care. The service is accessible throughout for people with mobility difficulties and has specialist equipment to support those who need it. At the time of the inspection 68 people were using the service.

The service did not have 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 and associated Regulations about how the service is run.

At our focused inspection on the 24 April 2015, we found that the provider had followed their plan and the legal requirement relating to medicines had been met. Systems were in place to ensure that sufficient amounts of people's prescribed medicines were available for administration when needed. The monitoring and checking of medicines management systems had improved and action was taken when required. Information was in place to ensure that staff knew how and when to administer medicines that were prescribed on an 'as required' basis or that should only be given under specific circumstances.

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?

We found that action had been taken to improve the safety of the service.

Systems were in place to ensure that people received their prescribed medicines safely.

Medicines management was monitored to ensure that it was safe.

Systems were in place to ensure that sufficient amounts of people's prescribed medicines were available for administration when needed.

This meant that the provider was now meeting legal requirements.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for safe at the next comprehensive inspection.

Requires improvement

Barleycroft Care Home

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.'

This inspection took place on 24 April 2015 and was unannounced.

This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection 15 and 16 October 2014 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 legal requirements in relation to that question.

The inspection was undertaken by a specialist pharmacist inspector. Before our inspection we reviewed the provider's action plan, which set out the action they would take to meet legal requirements.

At the visit we looked at the medicines administration records for 20 people. We spoke with the manager, two nurses and the provider's regional quality lead.

Requires improvement

Is the service safe?

Our findings

When we visited this service on 18 and 19 March 2014 we found that the provider was in breach of the regulation that related to medicines. We carried out an unannounced comprehensive inspection of this service on 15 and 16 October 2014 at which we found that this breach of legal requirements had still not been met. This was because the systems in place for the administration of medicines were not safe. Some people had not received all their medicines as prescribed which, was a risk to their health and welfare. Concerns identified in medicines audits were not responded to and there was no guidance for staff for the administration of medicines that were prescribed on an 'as required' basis or that should only be given under specific circumstances.

As a result of this we took enforcement action against the provider and a warning notice was served under Section 29 of the Health and Social Care Act 2008.

At our focused inspection on 24 April 2015 we found that the provider had followed the action plan they had written to meet the requirements of the warning notice described above.

We looked at the medicine administration records for 20 out of 68 people. We found there were no unexplained omissions in these records. We saw each unit now used a medicines communication book and that copies of faxed prescription requests to the GP surgery were kept in a file. This helped to ensure that requests for medicines were sent promptly and followed up appropriately. When new people were admitted to the home from hospital, a copy of the discharge summary was sent immediately to the surgery so the service was supplied with the correct medicines. Systems were in place to ensure that sufficient amounts of people's prescribed medicines were available for administration when needed.

We saw that where medicines were prescribed to be given 'when required, or where they were to be used only under specific circumstances, individual when required protocols, (administration guidance to inform staff about when these medicines should and should not be given) were in place. They provided information to enable staff to make decisions as to when to give these medicines to ensure people were given them when they need them and in way that was both safe and consistent. When people were prescribed "when required" tranquillising or sedating medicines, there was a full and accurate record of why they were given, on a separate behaviour chart. Systems were in place to ensure that people received their prescribed medicines safely.

We found that the monitoring and checking of medicines management systems had improved. There were weekly audits to check medicines were being administered correctly, and there was a monthly audit of medicines management systems. We saw that appropriate action was taken when required. Medicines management was monitored to ensure that it was safe.