Options for Care Limited

Orchard House

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Overall summary

We carried out this unannounced inspection on 30 September 2015 to look only at the arrangements in place for the proper and safe management of medicines. We found that a new manager had been appointed on 21 September 2015 and arrangements were in place to manage people's medicines safely.

Orchard House is registered to provide accommodation for six people with Learning Disabilities. There were three people living there when we inspected.

We last inspected this service on 26 and 27 August 2015. We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that the provider had not ensured that procedures were in place to protect people from the risk of abuse. This was a breach of Regulation 13. We found that care and treatment was not provided in a safe way. This was a breach of Regulation 12. Robust recruitment arrangements were not provided. This was a breach of Regulation 19. Arrangements in place did not ensure that sufficient numbers of staff were deployed to ensure people's needs were met. This was a breach of Regulation 18. Arrangements in place did not ensure that people's dignity was promoted. This was a breach of Regulation 10. The provider had not ensured that people were provided with person-centred care. This was a breach of Regulation 9. The arrangements for complaints did not ensure that the provider acted on complaints. This was a breach of Regulation 16. Arrangements in place did not ensure that the systems were established for good governance. This was a breach of Regulation 17. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Orchard House on our website at www.cqc.org.uk.

The provider sent us an action plan on 09 December 2015 detailing what action they had and will be taking to ensure that they meet the breaches of the regulations and keep people safe.

We did not review the rating of the service at this focused inspection. Services in special measure are kept under review and we will carry out a full inspection of this service within six months of the previous comprehensive inspection. This service will be inspected again before the end of February 2016 and we will review the rating.

Summary of findings

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

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?
People received their medicines as prescribed.

Inadequate

Orchard House

Detailed findings

Background to this inspection

We did not review the rating of the service at this focused inspection. Services in special measure are kept under review and we will carry out a full inspection of this service within six months of the previous comprehensive inspection. This service will be inspected again before the end of February 2016 and we will review the rating.

The inspection was unannounced and was carried out by one inspector on 30 September 2015. The inspector was a pharmacy inspector and they only looked at the safe management of medicines.

The inspector spoke with the manager and looked at the storage and arrangements in place for the administration of medicines. This included looking at three people's medicine records, staff training records and policies and procedures in relation to the administration of medicines.

Inadequate

Is the service safe?

Our findings

At our last inspection we found that people's medicines were stored in the office in a locked trolley. However, the office was not lockable. We saw that medicine's to be returned to the pharmacy were also stored in a bag in the office and this was not secured. We saw that Medication Administration Records (MAR) chart had not always been completed accurately and we saw records stating that some people had been given the medication at the wrong time of the day. We saw that some discontinued medicine was still being stored in the medicine trolley. Following our inspection we asked that a pharmacy inspector from the CQC visited the service to assess if people's medicines were managed safely.

At this inspection we only looked at the arrangements in place for the safe management of medicines. A new manager was employed on 21 September 2015 and we found that they had made improvements for the management of medicines.

We found that people were on the whole receiving their medicines as prescribed. We looked in detail at three medicine administration records and found that people were on the whole receiving their medicines at the frequency prescribed by their doctor.

We found the staff were aware of those medicines that had special administration requirements and were ensuring that these requirements were being followed. For example one particular medicine needed to be administered on an empty stomach, 30 minutes before any other medicines and food with a full glass of water. We found staff were aware of these requirements and processes were in place to ensure this guidance was followed.

We found the provider had introduced protocols for all those medicines that had been prescribed on a when required basis. We found that these protocols had sufficient information to show the staff how and when to administer these when required medicines.

We found that one person had been prescribed an emergency rescue medicine. We were concerned that only one member of staff had been trained to administer this medicine. We spoke to a member of staff and they confirmed they had not received any training to administer this particular medicine. They told us that if the situation arose they would not administer the medicine; instead they would immediately telephone for an ambulance.

We found medicines were being stored securely so that the people using the service were protected against the risks of the inappropriate administration of medicines. We also found that the provider had ordered cabinets so that each person's medicines could be stored securely in their bedroom. The use of cabinets to store medicines in people's bedroom would promote the administration process to be carried out in a more private and dignified manner.