Ryedowns Limited

Bridge House Care Centre

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service caring?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 18 December 2014 and a breach of legal requirements was found. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the management of medicines at the home.

We undertook this focused inspection to check the provider had followed their plan and to confirm they now met legal requirements. This report 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 Bridge House Care Centre on our website at www.cqc.org.uk

We undertook this unannounced focused inspection of Bridge House Care Centre on 1 June 2015. Bridge House Care Centre is a care home which provides accommodation for up to 35 people who require personal care and support. At the time of our inspection the home was fully occupied. The home specialises in caring for older people living with dementia.

The service is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager on our records left the service in October 2014. We were notified at the time by them and the provider. A manager was appointed to replace them but subsequently stepped down from the role. A new manager has been appointed from 26 May 2015 and is in the process of submitting the appropriate registered manager application to CQC.

Summary of findings

We found the provider had taken appropriate and timely action to make improvements in relation to the management of medicines at the home. Our checks showed people received their medicines as prescribed and appropriate records in relation to the management of medicines were maintained. We also found medicines in stock were all in date.

People's records gave guidance for staff on how and when to administer 'as required' medicines, topical creams and ointments. The provider had updated their medicines policy and procedure so that staff had clear guidance about their responsibilities for when to administer these medicines.

Regular checks of medicines had been undertaken by senior staff to ensure staff were administering and disposing of medicines as required.

The provider had taken steps to ensure staff were aware of how to ensure peoples' rights to privacy and dignity were upheld. Staff had received dignity training. However we found there were still some inconsistencies in the way information about people was used and discussed in the home which could compromise people's privacy and dignity.

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?

Good 

We found that action had been taken to improve safety. Records showed people received their medicines as prescribed. Staff were given guidance and instructions for the safe administration and disposal of medicines. Staff had received refresher training in the safe handling of medicines to support them to do this.

Senior staff carried out regular audits and checks to assure themselves that medicines were managed appropriately within the home.

We were able to improve the rating for 'Is the service safe' from requires improvement because we were able to see evidence of consistent good practice in relation to medicines management over time.

Is the service caring?

Requires improvement 

We found that action had been taken to improve how the privacy and dignity of people was maintained. Staff had been provided with dignity training.

However we saw there were still some inconsistences in the way information about people was used and discussed by staff.

We could not improve the rating for 'Is the service caring' from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Bridge House Care Centre

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 unannounced focused inspection was undertaken by a single inspector on 1 June 2015. It was done to check that improvements had been made by the provider after our comprehensive inspection on 18 December 2014. This is because the service was not meeting a legal requirement at the time of that inspection. The team inspected the service against two of the five questions we ask about services: Is the service safe? Is the service caring?

Before the inspection we reviewed the information we held about the service. This included notifications the provider is required to submit to the CQC. We also read the written report we asked the provider to send us, setting out the action they would take to take to meet the regulation they breached at their last inspection.

During our inspection we spoke with the home manager, the deputy manager and the clinical lead for the home, who was the home manager at the time of our last inspection. We observed interactions between people and staff.

We also looked at five care records and audits of medicines at the home.

Good

Is the service safe?

Our findings

On 18 December 2014 we inspected the service and identified a breach of the regulations with regards to the management of medicines. We found some medicines were not administered or disposed of properly by staff. There was no guidance for staff on how and when to administer 'as required' medicines and records were not kept of when some medicines such as creams and ointments had been administered. These failures meant people using the service were not protected against the risks associated with unsafe or inappropriate administration of medicines.

Following that comprehensive inspection the provider sent us an improvement plan in March 2015. They told us they had completed all the actions needed to meet the requirements of the regulations by the end of January 2015.

On 1 June 2015 we inspected the service to check whether or not the provider had taken all the action they said they would in their improvement plan. We found that improvements had been made to the management of medicines in the home to meet the requirements of the relevant regulation.

At our last inspection we identified medicines prescribed for one person had been administered to another individual. We also found expired medicines that had not been disposed of. Following the inspection disciplinary action was taken by the provider with the staff involved in the incorrect administration of medicines. The clinical lead had also held a staff meeting with all nursing staff to discuss the issues we raised to ensure all staff were aware of their responsibilities for administering the right medicines to the right people. Staff had also been made aware of their responsibilities for the disposal of expired and unwanted medicines. The provider had updated the home's medicines policy and procedure so that staff responsibilities were clear in relation to the disposal of medicines. All nursing staff were also provided with refresher training in safe handling of medicines.

During this inspection we saw medicines that were being administered to people, were in date. Records showed people were supported by staff to take their prescribed medicines when they needed them. People's individual medicines administration record (MAR sheet) showed staff signed this record each time medicines had been given. We found MAR sheets were appropriately completed when medicines were administered. We checked the stocks and balances of people's medicines which confirmed these had been given as indicated on people's individual MAR sheet.

People's records contained some guidance for staff on how and when to administer 'as required' medicines, creams and ointments. 'As required' medicines are medicines which are only needed in specific situations such as when a person may be experiencing pain. We discussed with staff how and when such medicines should be administered and staff were able to answer this satisfactorily. The provider had updated their medicines policy and procedure to ensure there was clear guidance for staff about the use of 'as required' medicines and topical creams and ointments.

Audits and checks of medicines were routinely carried out. Following the comprehensive inspection, the dispensing pharmacy had undertaken an audit of medicines at the home. Their report showed no issues or concerns were identified. The deputy manager had also undertaken monthly medicines audits and we saw from these the issues we raised had been incorporated as part of their monthly checks, to ensure these did not reoccur.

Requires improvement

Is the service caring?

Our findings

At our comprehensive inspection of Bridge House Care Centre on 18 December 2014 we saw an instance where an individual had not been treated with dignity or had their privacy respected. They had been left to use the bathroom in the dark, as the bathroom light was not working. The bathroom door had been partially left open. We discussed this at the time with the home manager who informed us they would take appropriate action.

On 1 June 2015 we inspected the service and checked what improvements had been made by the provider to address the concerns we raised. We found the provider had taken action to make improvements. Staff had received 'dignity training' and the former home manager had discussed the issues we raised with all staff on a one to one basis. The bathroom light had also been repaired.

However we identified there were still some inconsistencies in how the privacy and dignity of people was maintained.

We found lists identifying which people needed help with personal care and eating displayed in public areas around the home. As these lists could be viewed by people, and visitors to the home, the service was not ensuring that personal information about people was kept confidentially.

We also observed interactions between staff and people using the service. Although staff were friendly and helpful we overheard on one occasion a conversation between two staff who were talking about a person that needed to be supported to use the bathroom. The language used by staff was not dignified and compromised the privacy of the individual concerned. This is because the conversation took place in a public area and was loud enough that it could easily be overheard by others. We discussed these inconsistencies with the clinical lead and home manager and the lists were removed during our visit. The home manager told us they would reiterate with staff the need to maintain people's privacy and dignity.