Grantham and District Mencap Limited

Fairview Farm

Inspection report

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Ratings

Is the service safe?	Requires improvement

Overall summary

We carried out an announced comprehensive inspection of this service on 25 February 2015 and found that there was a breach of legal requirements. The service was not consistently safe. This was because the registered persons had not ensured that medicines were always managed safely.

We completed an announced focused inspection on 7 August 2015. This inspection was undertaken to make sure that improvements had been made and that the breach of legal requirements had been addressed.

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 Fairview Farm on our website at www.cqc.org.uk.

Fairview Farm provides accommodation for up to 22 people who have a learning disability. There were 21 people living in the service at the time of our inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are a 'registered person'. The registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found that the registered persons had followed their action plan that they had told us would be completed by 27 April 2015. This action plan had enabled the registered persons to meet legal requirements.

We found that the registered persons had strengthened the way in which medicines were managed. The improvements had better enabled the registered persons to ensure that people reliably received all of the medicines they needed. However, further improvements were still needed to eliminate a small number of remaining errors in the way that people were supported to use medicines .

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 way in which the service kept people safe. This involved having arrangements that more robustly ensured that people safely received their medicines.

This meant that the registered persons were now meeting legal requirements.

However, further improvements were still needed to extend the developments that had been made. Given this situation, we have not revised the rating for this key question. We require an appreciable track record of consistent good practice in order to improve the rating to 'Good'.

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

Requires improvement

Fairview Farm

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 registered persons were meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We completed an announced focused inspection of Fairview Farm on 7 August 2015.This inspection was undertaken to check that improvements to meet legal requirements planned by the registered persons after our comprehensive inspection on 25 February 2015 had been made.

We gave the registered persons a short period of notice before we called to the service. This was because the people who lived in the service had complex needs for care and benefited from knowing that we would be calling. The inspection team consisted of a single inspector.

We inspected the service against one of the five questions we ask about services: Is the service safe? This was because the service was not meeting legal requirements in relation to that question.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the registered persons had sent us since the last inspection.

During the inspection we spoke with two people who lived in the service. We also spoke with a care worker, senior care worker and the registered manager. We observed care being provided in communal areas including the administration of medicines. We looked at the care records for two people who were assisted by staff to manage their medicines. In addition, we looked at records that described how medicines had been administered and reviewed documents that provided staff with guidance about managing medication. We also looked at the arrangements used to order, store and dispose of medicines.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection on 25 February 2015 we found that the registered persons had not ensured that there were consistently reliable arrangements for managing people's medicines. This was because there had been a significant number of occasions on which medicines had not been correctly administered. In addition, effective action had not always been taken to ensure that people were kept safe when mistakes had been made. We also found that staff were not always correctly recording medicines they dispensed and that quality checks had not effectively identified and addressed these problems.

This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the registered persons had followed the action plan they had prepared. The improvements they had introduced had met the requirements of Regulation 12 we have described above.

We found that the registered persons had taken action to significantly reduce the number of occasions when medicines were not correctly dispensed. These changes included introducing a new system to store medicines that was easier to use and was less likely to result in errors occurring. In addition, staff who administered medicines had received additional training in how to use the new system. They had also received further guidance about how to accurately record each occasion on which they dispensed a medicine.

In addition, the registered persons had introduced additional quality checks to help ensure that people were assisted to use the right medicine at the right time. These checks included staff checking each person's use of medicines three times a day. The registered manager was also completing new monthly audits of how well the system was working. These audits were being completed to double check that people were being assisted to use medicines in the right way. A person who lived in the service and who had special communication needs smiled and gave a thumbs-up signs when we pointed at the medication trolley.

Records showed that the number of occasions when people had not been given their medicines in the right way had been significantly reduced. However, two mistakes had been made and on both occasions staff had not responded correctly. This was because they had not followed the registered persons' guidance and obtained medical advice to ensure that people were kept safe. However, care records showed that the two people concerned had not experienced any direct harm as a result of this mistake. In addition, the registered manager had established how each mistake had occurred and had taken action to help prevent the same thing from happening again. This included staff making sure that they were not distracted when dispensing medicines. In relation to this we observed a member of staff dispensing medicines and noted that they were wearing a red tabard that asked people not to interrupt them. We also noted that they were correctly dispensing medicines and accurately recording each occasion.

The registered persons had taken the necessary steps to meet legal requirements and to ensure that people were consistently supported to use medicines safely. However, further improvements were needed to eliminate mistakes and to respond appropriately when things did go wrong.