Baytree Community Care (London) Limited

Baytree Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 27 September 2016 and found there were two breaches of regulations, one in relation to staffing, the other for the safe administration of medicines. We took action against the provider and issued a Warning Notice in relation to the breach relating to medicines. We told the provider they must meet the requirements of this regulation by 28 November 2016.

At the inspection on 27 September 2016 we found that medicines were not all stored safely. There were discrepancies when we checked stocks against records. This was of concern as the provider could not satisfy themselves that all medicines were safely accounted for. Also the medicine system was not easy for staff to use for two of the people living at the service. These concerns were a breach of the regulations.

Baytree Lodge is a care home registered for a maximum of twelve adults who have mental health needs. At the time of our inspection there were twelve people living at the service. The provider is also registered to provide personal care at a supported living unit next door. This inspection relates to the care home service only. The service is located in two large adjoining houses, on two floors with access to a back garden.

At the time of the inspection there was no registered manager in place. Baytree Lodge have not had a registered manager actively managing the service since September 2015. However the manager recruited to run the service in September 2016 had put in their application to the Care Quality Commission to become the registered manager at the time of writing this report. 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 undertook an unannounced focused inspection on 17 January 2017 to check that the service was now meeting legal requirements in relation to the Warning Notice served in October 2016. This report only covers our findings in relation to this requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Baytree Lodge on our website at www.cqc.org.uk . We did not inspect the other breach of regulations at this inspection but will do so when we return to carry out our next comprehensive inspection.

At the inspection on 17 January 2017 appropriate arrangements were in place for recording the administration of medicines. Stocks tallied with records and medicines were stored securely. People received their medicines when they needed them and there were no gaps in recording on medicine administration records (MAR). The provider had updated their procedures following the inspection in September and staff were now working to these new arrangements.

We judged that the provider had made improvements and had met the requirements of the Warning Notice. As improvement have been made we are able to change the rating for the Safe domain to good.

We will review the overall ratings for the service at our next comprehensive inspection.

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

The service was safe. Medicines were safely administered and managed. New procedures to improve the safety of people's medicines support had been introduced following the inspection in September 2016 and staff were working to these.

Baytree Lodge

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.

We undertook an unannounced focused inspection of the service on 17 January 2017. This inspection was carried out to check that the provider had addressed the legal requirements of a Warning Notice served in October 2016 for breach of regulations relating to safe care and treatment for people who used the service.

The inspection team consisted of a pharmacist inspector. The team inspected the service to check medicines management within the domain: Is the service safe?

Before the inspection we reviewed information we held about the service in our records. This included information sent to us by the provider relating to safeguarding alerts and notifications of important events at the service.

We reviewed medicines administration records (MAR) for 12 people who used the serviced and checked stocks against MAR sheets for six people. We looked at storage facilities and audit sheets that showed management oversight of medicine stocks against records.

Good

Is the service safe?

Our findings

At the inspection on 27 September 2016 we checked records related to medicines and medicine stocks. We noted that for two people the dates of the medicine administration record (MAR) did not tally with the blister pack. For example, whilst the MAR showed people were on week one of the four week cycle, week four of the blister pack was in use for both people. This was of concern as it meant it was not easy to tell if people had had their tablets, and it assumed all staff knew that they were to give tablets from week four of the blister pack.

At this inspection we found the blister pack system for dispensing medicines was clear for staff to use, and the MAR tallied with the blister pack.

At the previous inspection one of the people using the service routinely refused medicines once they had been taken out of the blister pack. These tablets were not stored and labelled safely. The number of refused tablets on the MAR did not tally with stocks to be returned to the pharmacist. This was of concern as the provider could not account for these missing tablets. We checked stocks against the MAR for another person and found there was an error and two tablets were missing.

Following the inspection in September 2016 we spoke with the Director of Quality and Systems for the service who told us they would introduce a protocol to inform staff how to manage refusals of medicines. At this inspection we saw that the protocol had been introduced and any refused medicines were now stored and labelled safely prior to being returned to the pharmacist.

At this inspection we saw six people were prescribed medicines that may require monitoring or blood tests and that these were taking place as required. We also saw medicines were stored securely. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. Since the last inspection a new cupboard had been installed which was used to securely store the next month's medicines.

At the last inspection we could see that medicines audits had been taking place weekly, but stocks were not checked against records so the audit process was not effective. At this inspection we could see the provider did daily checks to ensure the administration of medicine was being recorded correctly by checking the stock balance of medicines supplied in boxes. This meant any errors or discrepancies could be quickly identified.