Barchester Healthcare Homes Limited

Bloomfield

Inspection report

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Ratings

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

Summary of findings

Overall summary

We carried out a comprehensive inspection of Bloomfield on 16 August 2016. Following this inspection we served two Warning Notices for breaches under two separate regulations of the Health and Social Care Act 2008. In addition to this, we also found three further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of the Care Quality Commission (Registration) Regulations 2009 was also identified. We have set requirement actions relating to these breaches.

We undertook a focused inspection on 1 November 2016 to check the provider was meeting the legal requirements for one of the regulations they had breached that resulted in them being served a Warning Notice. This focused inspection was to ensure the provider had taken sufficient action that ensured people were protected against the risks associated with medicines. This report only covers our findings in relation to this areas. You can read the report from our last comprehensive inspection, by selecting the 'All reports' link for 'Bloomfield' on our website at www.cqc.org.uk

Bloomfield provides accommodation for people who require nursing or personal care to a maximum of 102 people.

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 '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.

During this focused inspection on 1 November 2016, we found that sufficient action to achieve compliance with the safe and proper management of medicines had been achieved. The management at the service had introduced daily governance systems since our last inspection. This ensured that records relating to medicines were checked a minimum of twice daily for any recording errors or omissions. At shift handovers, additional documentation had been introduced between nursing staff that confirmed stock levels had been checked. All of the people who required pain relieving transdermal patches and skin creams had been individually reviewed and new documentation detailing their needs had been produced for staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service had taken action to ensure people were protected against the risks associate with medicines.

We could not improve the rating for this key question from inadequate; there are additional breaches of separate parts of this regulation under this key question. In addition we would require a record of consistent good practice over time. We will review our rating for safe at the next planned inspection.

Bloomfield

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. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Following our inspection on 16 August 2016, we served two Warning Notices for breaches of two separate regulations under the Health and Social Care Act 2008. During this inspection we checked that the improvements required by the provider after our comprehensive inspection had been made in relation to one of those regulations. The regulation we inspected against related to ensuring people were protected against the risks associated with medicines.

We undertook a focused inspection of Bloomfield on 1 November 2016.

The inspection was unannounced and undertaken by one inspector. The inspection involved inspecting the service against one of the five questions we ask about services which was, 'Is the service safe.'

During our inspection we spoke with the deputy manager and three nurses. We looked at people's individual records relating to their medicines and governance systems that monitored staff medicine administration practice.

Inadequate

Is the service safe?

Our findings

At the inspection of Bloomfield on 16 August 2016, we found that people were not always fully protected against the risks associated with medicines. We served a Warning Notice that required the provider to meet the legal requirements of this regulation by 30 September 2016. At our focused inspection on 1 November 2016 we found the service had taken action to ensure people were protected against the risks associate with medicines.

The service had introduced effective systems that had significantly reduced recording errors and omissions in people's Medicine Administration Records (MAR). MAR are used to record the administration of prescribed medicines. During handovers between shifts all nursing staff were required to review each individual MARs for people and sign to confirm that there were no recording errors or omissions. This meant that people's MAR were reviewed a minimum of twice daily. In addition to this, all relevant records confirming these checks had been completed and signed for were presented to the service management daily at a meeting. This ensured the management at the service could confirm these checks had been completed. We spoke with three members of nursing staff who told us this new system and level of responsibility and accountability had impacted positively. They told us recording errors and omissions were now very minimal. A review of a sample of people's MAR on all four units within the service showed the current system was effective as no recording errors were identified.

New governance systems that monitored the management of Controlled Drugs (CD) have been effective. CD are medicines which are at higher risk of misuse and therefore need closer monitoring. At our last inspection we found the service had failed to immediately identify and respond to the loss or theft of a CD. The service management had introduced an effective system to reduce the risk of reoccurrence. The CD cabinet was now checked a minimum of twice daily by nursing staff to ensure stock levels were correct at handover. We reviewed the CD register on all four units within the service and saw these checks had been completed. In addition to this, the CD register for each unit was presented to the service management daily at a meeting for review. This ensured the management at the service could confirm these checks had been completed. We also completed a check on the balance of some CD against the register on two of the units within the service. The balance held matched the records within the CD register.

The service had ensured people who had been prescribed transdermal pain relief patches had been reviewed and appropriate records were maintained. At our last inspection we found people were not fully protected against the risks associated with these medicines as there were not always records showing where the patch had been applied on the person's body. This presented a risk as the siting of the patch on the person's body required regular rotation. During this inspection we found that all of the relevant people in the service had been reviewed and accurate records were now maintained. These records contained a body map which showed the site of the patch application, the date it was applied, when it was removed and which member of staff removed it. We reviewed a sample of records on all four units which had been accurately competed.

Risks associated with the application and storage of topical creams had been reduced. At our last inspection

the service could not demonstrate people had received their topical creams as prescribed and guidance for staff was not clear. People's creams had not always had the date recorded when they were opened which meant it could have been used past the manufacturers recommended expiry date. The service had undertaken a review of all people who received a topical cream. New records had been produced for people giving guidance for staff on the frequency of cream application and a body map showing staff where the cream should be applied. We reviewed a sample of records on all four units that demonstrated these records had been completed consistently and people had received their creams as prescribed. In addition to this, we checked a sample of creams that demonstrated they had been labelled when opened and a date had been recorded when the cream should be disposed of.

Additional management governance systems were in operation that monitored the safe use of medicines. As detailed above, a daily management meeting had been introduced which ensured staff handovers had been completed correctly and records had been completed. In addition to this, the service management completed sample audits of people's MAR and associated documents to ensure there were no recording errors or omissions. The deputy manager told us they sampled 10 people's MAR a week as part of their daily checks.