Castel Froma

The Helen Ley Care Centre

Inspection report

Bericote Road
Blackdown
Leamington Spa
CV32 6QP
Tel: 01926 313550
Website: www.helenley.org.uk

Date of inspection visit: 2 October 2015
Date of publication: 09/11/2015

Ratings

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

Overall summary

The Helen Ley Care Centre provides respite and full time nursing care for up to 35 people with neurological conditions. At the time of our inspection there were 26 people receiving care at the home.

We previously carried out an unannounced comprehensive inspection of this service on 3 and 6 March 2015, at which a breach of the legal requirements was found. This was because medicines were not safely managed in the home.

As a result of the breach of the legal requirements and the impact this had on people who lived at The Helen Ley Care Centre, we rated the key question of 'Safe' as 'Requires improvement'. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for 'The Helen Ley Care Centre' on our website at www.cqc.ork.uk.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to the breach.

We undertook a focused inspection on the 2 October 2015 to check that they had followed their plan and to confirm they now met the legal requirements. At this inspection we found the requirements had been met.

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 and associated Regulations about how the service is run.

Appropriate arrangements were undertaken to manage the risks associated with the unsafe use and management of 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?

Good

The service was safe.

Action had been taken to improve the safe storage and administration of medicines in the home. People received their medicines as prescribed.

This meant the provider was now meeting legal requirements and we have revised the rating to 'good'.

The Helen Ley 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 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 a focused inspection of The Helen Ley Care Centre on 2 October 2015. This inspection checked that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 3 and 6 March 2015 had been made. We inspected the service against one of the five questions we ask about services: 'Is the service safe?' This is because the service was not meeting legal requirements in relation to that question. The inspection was undertaken by two inspectors and a pharmacy inspector.

Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements.

At this visit to the home we spoke with two nurses. We also looked at seven people's medication records and checked the storage and management of medicines.

Good

Is the service safe?

Our findings

At our comprehensive inspection on 3 and 6 March 2015 we found the provider did not ensure that medicines were always managed safely in the home. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Medication.

At our focused inspection on 2 October 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 13.

We looked at how medicines were stored and the medicine administration records for seven people. We found that appropriate arrangements were undertaken to manage the risks associated with the unsafe use and management of medicines.

People's medicines were available to treat their diagnosed health conditions. Medicine administration records (MARs) confirmed people had been given their medicines as prescribed. MARs were mostly clear and accurate, apart from one person's medicine instructions which had been amended and the amendments were not clear.

We looked at the records for one person who had medicine through skin patches applied to their body. There are specific requirements in the administration of patches such as the same site should be avoided for a certain period of time. Records were maintained of where the patches had been applied to ensure they were being used safely.

Suitable arrangements were in place for accurate medicine stock checks. This meant it was possible to check the balance of all medicines to ensure they had been given as prescribed.

Supporting information for staff to safely administer medicines was not always available. In particular we looked at one person who was prescribed a medicine to be given 'when necessary' or 'as required' for agitation. There was no supporting information available to enable staff to make a decision as to when to give the medicine. However, records showed the medicine had not been given which meant it had not been given unnecessarily.

We looked at the procedure for managing medicines that required extra checks and special storage arrangements. We found these medicines were being stored and managed in accordance with the necessary legal requirements.

One person had chosen to 'self administer' their medicines. There were risk assessments and checks in place to ensure the person was taking their medicines as prescribed.

We were shown copies of checks which identified any issues or errors in the management of medicine. Medicine errors were dealt with immediately in order to learn and prevent the error happening again. There was an open culture of reporting medicine problems. We also found that there was shared learning to ensure the error did not happen again.