Brendoncare Foundation(The)

Brendoncare Chiltern View

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

Brendoncare Chiltern View is a nursing home for adults who have dementia. Brendoncare Chiltern View is registered to provide accommodation for 30 people.

This focused inspection took place on 3 November 2016. It was conducted to follow up on previous enforcement action taken.

We previously inspected the service on 23 and 27 May 2016. We found continued breaches of the Health and Social Care Act 2008. We found people who used the service were not protected against the risk of unsafe or inappropriate care in regards to medicines. We took enforcement action to ensure people's safety and ensure improvement occurred at the service. We served a warning notice to the provider following the inspection. A warning notice gives a date the service must be compliant by. The date the service needed to be compliant was 31 July 2016. We asked the provider to send us an action plan detailing how they intended to improve. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Brendoncare Chiltern View' on our website at www.cqc.org.uk.

The service had 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.

We have not provided a rating for this inspection as we only looked at the management of medicines.

We found on-going issues around the storage, recording and administration of medicines. There were ineffective systems in place to ensure risks were minimised around medicines.

We found the service did not have an accurate record of what medicine had been delivered or administered to people.

Since the last inspection the registered manager had increased the monitoring they conducted on the management of medicines. We found the storage and recording of control medicines were correct.

We found continued breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not protected against unsafe practice regarding medicine management.

There were ineffective systems in place to manage medicine safely.

Brendoncare Chiltern View

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, and to follow up on previous enforcement action.

The focused inspection took place on the 3 November 2016 and was unannounced; this meant that the staff and provider did not know we were visiting. The inspection was carried out by one inspector.

Before the inspection the provider was not asked to complete a Provider Information Return (PIR). The PIR is a form that the provider submits to the Commission which gives us key information about the service, what it does well and what improvements they plan to make. We reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

Before the inspection we looked at the action plan the service sent us and other information we held about the service. We also contacted social care and healthcare professionals with knowledge of the service. This included people who commission care on behalf of the local authority and health or social care professionals responsible for people who lived in Brendoncare Chiltern View.

We looked at five people's medicine stock and records relating to them. We spoke with the registered manager and deputy manager. We looked at records the registered manager had completed to drive improvements around medicine managements.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection carried out on 23 and 27 May 2016 we found people who received care and treatment were not protected from avoidable harm. We found multiple breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found people were not supported with their medicines in a safe way. The storage and stock management of medicine could have led to people receiving harmful medicines. We also found staff did not always follow risk assessments for how to support people safely when helping them to change position.

We took enforcement action to ensure people's safety and ensure improvement occurred at the service. We served a warning notice to the provider following the inspection. A warning notice gives a date the service must be compliant by. The date the service needed to be complaint was 31 July 2016. We asked the provider to send us an action plan detailing how they intended to improve. At this inspection we looked for evidence the service had made the required improvements to satisfy the warning notice.

We found some improvements in the way medicines were managed. The service had introduced a new electronic medicine management system. This had helped with the stock control and highlighted to staff if a medicine had been missed. The deputy manager told us they checked this every morning prior to the night staff leaving. They were then able to establish if the medicine had been given or not. The registered manager told us each medicine cycle was four weeks. They also told us any medicine not used in any cycle would be returned to the pharmacy They told us each cycle commenced with new stock. This is not what we found. We found continued breaches of Regulation 12 of the Health and Social Care Act 2008.

On the day of inspection, a medicine that should only be given on the same day once weekly had been highlighted on the system as missed, however it was not due on that day. We checked the stock of this medicine. We found four tablets had been dispensed from the pharmacist on the 24 October 2016. The medicine cycle at the time of our inspection commenced on the 31 October 2016 and the four tablets had been supplied for that cycle. We found two of the tablets had been used. The first date the medicine was required in that cycle was the 4 November 2016. We asked the registered manager and deputy manager about this and looked at the medicine administration record (MAR). We saw the MAR recorded that a tablet had been given on the 31 October 2016 and 1 November 2016, again not the days the medicine was required. A registered nurse had signed the MAR. We asked the deputy manager to contact the nurse whose had signed the form. The deputy spoke with the registered nurse who confirmed that they had given the person the medicine on the 1 November 2016 even though the dispensing label referred to a different day of administration. The nurse informed the deputy manager she was aware the medicine should only be given once weekly. However they had not looked at the MAR for the 31 October 2016, so had no knowledge it had been given the day before. The MAR had shown the medicine was also due on the 2 November 2016, again not the correct day of administration. The nurse informed the deputy manager that they had told the incoming nurse the medicine was not given. The incoming nurse had recorded the medicine was not given for a clinical decision. We asked the deputy manager why the electronic system showed the medicine was due when it was not. They told us it had been entered incorrectly. This meant the electronic system did not reflect when the medicine was due and the person had received an overdose of the medicine. This could

have led to a decline in the person's health.

We found three boxes of the same medicine which amounted to 100 tablets. The person had taken or the service had disposed of 26 tablets. We counted the remaining stock. There were 92 tablets left in stock. This meant 18 tablets had been given from somewhere else. We asked the registered manager how many tablets had been dispensed for that cycle. They could not tell us how many had been dispensed. They contacted the pharmacist who advised they had provided 100 tablets on 18 October 2016 and 100 tablets on 24 October 2016. We found no record the service had received 200 tablets. The registered manager and deputy manager were unable to use the electronic system or find any other records to show how many tablets had been received and when. This meant the service did not have adequate control or management of medicine stock.

We found one person had been prescribed a tablet twice daily. The information on the MAR sheet did not tally with the dispensing label from the pharmacist. The MAR stated the person should have one tablet in the morning and two tablets in the evening. The person had two boxes of the medicine. One box contained 28 tablets and the other box contained 84 tablets. The dispensing labels stated the person should receive two tablets in the morning and two in the evening. The box that contained 84 tablets had been altered to say only one tablet was required in the morning. The alteration had not been signed by a member of staff. The other box had not been altered. We spoke with the registered manager and deputy manager about this. The deputy told us they had received a letter from the GP to advise to only give one tablet in the morning. They told us they would usually request a new dispensing label when changes to medicine were made, but had not requested this. We checked the remaining stock. This did not show the correct number of tablets left. This meant there was a risk the prescribing advice from the GP was not followed. This did not provide staff with accurate information to ensure safe administration of medicines.

The same person was prescribed as required medicine (PRN) for the management of diabetes. We found this was not recorded on the MAR. The medicine had been dispensed on 14 February 2016 and was in date. We saw one tube of the medicine had been used; however there was no record when this had been used. We asked the registered manager if PRN should be recorded on the MAR. They told us it should be.

At the last inspection we found the service had a surplus stock of insulin pens. The service had been working with the Clinical Commissioning Group (CCG) pharmacist to improve the management of medicine stock. Since the last inspection the registered manager had undertaken regular checks on insulin stock. They told us only one insulin pen should be stored in the person's medicine cabinet. We found two pens stored in the person's cabinet. Both pens had been used. We asked the registered manager how this had happened. They could not tell us, they removed one of the pens from the cabinet.

At the last inspection we found the service had received an action plan from a pharmacy audit conducted on 8 March 2016. The audit had highlighted creams which required an opening date had no date on them. This meant some creams may have become harmful if used. We also found opening dates had not been put on eye drops when this was needed. At this inspection we checked if the service had put measures in place to ensure staff put an opening date on eye drops and creams when needed. There were no eye drops prescribed at the time so we could not check this. We did check creams. Two people were prescribed creams. One pump bottle had been dispensed on 24 October 2016 and had not yet been opened. The other pump bottle had been dispensed on 29 June 2016. It had no opening date on it. The manufacture guidance on the bottle stated the cream was only able to be used for three months from the opening date. As there was no date recorded the service could not be sure this was still safe to be used. The deputy manager agreed to dispose of the cream immediately.

These were all continued breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Since the last inspection, the registered manager had increased their monitoring of the administration of medicines. They undertook a weekly stock check of seven people's medicines. If they found any discrepancies these were discussed with the nurse manager. The overstock of insulin pens were labelled to highlight which pen should be used first. The registered manager checked the insulin pen stock on a weekly basis.

The registered manager told us they ensured two nurses completed the morning medicine round. In the evening a nurse was supported by a senior care worker who had received training in the safe administration of medicine. However, on the day of the focused inspection we observed only one nurse on duty in the morning. This meant the service had not followed its procedures for the safe administration of people's medicines.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured it provided people with safe administration of medicines.

The enforcement action we took:

We imposed a condition of the providers registration.