Brandon Care Limited

Brandon House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 5 and 8 October 2015. The overall rating was 'good'. After that inspection we received concerns in relation to medication management and delays in responding to changes in people's health. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those/this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Brandon House on our website at www.cqc.org.uk

We judged that improvements were needed in the security of some medication storage and in the auditing of some medication. However, other medication records were well completed and records showed people were supported with their pain relief in the way prescribed for them. We spoke with two people, who told us they were happy with the way they received their medicines and that they were given them at regular times.

Records showed staff recognised changes in people's health and well-being and people had access to healthcare professionals.

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

One aspect of the service were not safe.

Some medication storage was not secure while audits for medicines needing additional security had not been effective .

Is the service effective?

Good

The service was effective.

People were supported to access healthcare services to meet their needs.

Brandon House

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 regulation associated with medicines and people's health and welfare under the Health and Social Care Act 2008. The team inspected the service against two of the five questions we ask about the services: is the service safe and is the service responsive.

We visited Brandon House on 22 June 2016. The inspection was unannounced and was carried out by two CQC inspectors, one of whom was a member of the medicines team.

We reviewed information about the service before the inspection. This included contacts about the home, previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to tell us about by law.

We spoke with two people who used the service and a relative of one of the people. We spoke with the provider and a staff member. We reviewed records relating to medication practice and looked at a range of care records for six people, and the home's communication book for staff.

Requires Improvement

Is the service safe?

Our findings

A concern had been reported to us about the way medicines were stored and managed in the home. During this inspection we looked at arrangements for storing and recording of medicines.

We found that some areas of medicines management needed to be improved.

Medicines were stored in a temporary location in the office whilst the permanent room was being refurbished. However not all medicines were stored securely at the time of our inspection. Staff had left some medicines out on a desk, and the medicines refrigerator was not locked. The key to the cupboard containing medicines needing additional security was not kept securely. This meant that some medicines were not securely stored and might be accessible to people not authorised to access medicines in the home.

Staff used a register to record the use of medicines needing additional security. The balances for two items recorded in the register did not match the amounts in the cupboard. After the inspection, the registered manager sent us a record showing that one of these items had been returned to the pharmacy in 2014, but staff had not recorded this in the register.

However two pain relieving patches were still within a box labelled for the person whose medicines had been recorded as being returned in 2014, and the number available for another person who was prescribed these patches was two short. The registered manager told us that she did monthly checks of the medicines requiring additional security. However she had not identified any inconsistencies and there were no written records confirming that these checks had been completed. This meant there was no clear audit trail of what medicines had been checked and when, which made it difficult to review when these errors had occurred.

This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our inspection, the provider has told us that she has now instigated a further cross check, and now records batch numbers and expiry dates when booking these medicines in. This should help to prevent this happening again. We looked at MAR charts for six people in the home, and found that these were well completed when people were given their medicines. Records showed that people were supported with their pain relief in the way prescribed for them. We spoke with two people, who told us they were happy with the way they received their medicines and that they were given them at regular times.

Good

Is the service effective?

Our findings

A concern had been reported to us about delays in contacting health professionals. During this inspection we saw there were arrangements for contacting health professionals in a timely manner.

Care records for six people living at the home and the staff communication book showed staff recognised changes in people's health and reported them in a timely manner. A memo showed the provider had taken action to remind night staff of their responsibilities to make a call to 111 in a timely manner after a reported delay. Minutes from a team leaders' meeting in June 2016 showed a commitment to provide good care and recognition of the importance of good communication between team leaders. The provider had instigated the meeting to promote effective team work.

Care records were up to date but work was needed to ensure records consistently showed the actions taken to address people's physical and mental health needs. For example, in the staff communication book night staff had recorded a person had been complaining of stomach pain and had requested to see a GP. A senior staff member related this pain to the person's anxiety, which was reflected in pre-admission information but the symptoms of their anxiety were not covered in their care plan. A care plan helps guide staff to how they should respond to people's individual care needs. The staff member updated their care plan. The provider said a member of the community team had met with the person to discuss their anxiety and health issues but this had not been recorded at the time of the inspection.

We met with two people who had fallen recently while in their rooms; they expressed satisfaction with their care and both confirmed they were not in pain following their falls. One person's records showed staff had been advised by 111 staff to call a GP in the morning. The person told us a community nurse had checked them over whilst visiting to monitor another health need; they had not seen a GP. On this occasion, an accident form had not been completed and the health professional had not recorded they had assessed them following their fall. The person's relative told us they were "very happy" with the standard of care.

The second person told us they had not requested to see a GP as they were not in pain following their fall. They said staff were "very kind" and would not make any changes to the care they received. The service used a risk assessment falls tool, which prompted staff to consider involving health professionals to help reduce or manage the risk of further falls. The provider provided us with an example of where a referral to a GP had been made following a person falling. An accident form had been completed and CQC were notified appropriately.

Entries in people's individual daily notes were informative and noted people's physical and mental well-being, as well as the person's views on their own health and mood. The provider described the actions they had taken to contact a person's mental health professional and GP when the person's mental well-being had declined. Staff recognised the person's low mood and the impact this had on their diet and attitude to medication. Monthly review forms regarding people's care were signed by people living at the home. The forms also documented changes, such as a person's leg becoming more painful and what action was taken, for example the community nurse team visiting.

People's care records showed a range of health professionals had regular contact with people living at the home, including GPs, community nurses, chiropodists and eye care professionals. A member of the local speech and language team was providing training to staff and told us their team were contacted appropriately.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way as there was not proper and safe management of medicines. Regulation 12 (1).