Leonard Cheshire Disability

Arnold House - Care Home Physical Disabilities

Inspection report

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Ratings

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

Summary of findings

Overall summary

At our previous inspection of this service on 15 September 2015, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation relates to the management of medicines. The provider sent us an action plan after the inspection detailing how they would address the breach. At this inspection we found that progress had been made, medicines were managed safely and the provider was no longer in breach of this regulation.

This inspection took place on 28 June 2016 and was unannounced. This inspection was carried out by a single pharmacist inspector. This report only covers our findings in relation to the safe management of medicines within the safe section. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Arnold House on our website at www.cqc.org.uk

Arnold House provides accommodation for up to up to 23 people with physical disabilities. On the day of the inspection there were 17 people residing at the home.

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.

We were assisted during our inspection by the registered manager.

All of the issues we found with medicines at the last inspection had been addressed. The records of the receipt and administration of tablets matched with the amount of tablets left in the medicines trolley. We saw that the allergy status had been updated and recorded in peoples' medicines administration records (MAR) and care plans.

The provider was no longer in breach of the medicines regulation, Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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. The provider had made the necessary improvements to the management of medicines.

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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 checked 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 Arnold House on 28 June 2016. This inspection was done to check that improvements to meet good practice requirements planned by the provider after our last inspection on 15 September 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 one of the requirements. The inspection was carried out by a single pharmacist inspector.

Prior to the inspection we checked the action plan that the provider sent us following the inspection in September 2015. We also looked at notifications the provider had sent us that are required by law under the Health and Social Care Act 2008. During the inspection we looked in detail at records relating to the safe management of medicines at the home, records related to medicines administration, and how medicines were stored.

Good

Is the service safe?

Our findings

At our last inspection of the service on 15 September 2015, we found that the provider was in breach of the regulation relating to medicines management. At that time the records of the receipt and administration of tablets did not match with the amount of tablets left in the medicine trolley. This meant that it was not possible to keep a check on the amount of medicines in stock at the home. We also saw that, in some cases, people's allergy status had not been recorded or updated.

The provider sent us an improvement plan, setting out how they would address the breach.

At this inspection we found that all of the issues relating to the safe management of medicines we reported on our last inspection had been rectified.

The records of the receipt and administration of tablets matched with the amount of tablets left in the medicines trolley. We saw that the allergy status had been updated and recorded in peoples' medicines administration records (MAR) and care plans.

Medicines were stored safely in the treatment room at the service. This room was clean, orderly and kept locked when not in use. The deputy manager told us that the medicines room keys were always kept with a member of staff in charge and were not left unattended or with unauthorised staff. All of the cupboards within the rooms which contained medicines were also locked. There was a separate controlled drugs cupboard. This was secure, and complied with the legal requirements of the Misuse of Drugs (Safe Custody) Regulations. We checked the stocks of controlled drugs against the balances in the controlled drugs register, and these tallied.

We checked medicines administration records for people living at the service and saw that these were completed clearly and in full. These records showed that medicines were available, and people were receiving their medicines as prescribed. There were no gaps in the recording of administration on any records. Each person had a resident profile, which listed any allergies, how people preferred to take their medicines, and a photograph to aid identification. The date of the photograph was recorded, so we were able to check that these photographs were recent.

Staff responsible for administering medicines had received medicines training and there were formal documented assessments of their competency to administer medicines. There was an induction pack for agency staff, which permanent staff went through with agency staff before they began their shift, and this induction pack included an overview of the provider's medicines policy.

For people prescribed pain relief, pain-rating scales were in use, to assess people's level of pain, and to help staff make a decision on whether people's pain was being managed adequately. This was particularly useful for people living with physical disabilities, who may not be able to communicate their pain well.

Therefore the issues noted at the last inspection had been addressed, and the provider was no longer in

breach of the medicines regulation, Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).