Sanctuary Care Limited

Briarscroft Residential Care Home

Inspection report

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10 May 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We last carried out a comprehensive inspection at this service on 27 February 2017. The inspection was unannounced and we found that there was a breach of regulations because people were not always getting their medicines as prescribed.

Following that inspection we issued a Warning Notice to the provider on 13 March 2017. The provider sent us an action plan detailing the actions they would take to address the shortfalls. At this inspection, carried out on 10 May 2017, we saw that improvements had been made to the way in which medicines were managed so that people received their medicines as prescribed.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Briarscroft Residential Care Home' on our website at www.cqc.org.uk'

Briarscroft Residential Care Home can provide personal care to up to 66 people. At the time of our inspection there were 54 people living in the home.

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. At the time of this inspection there was no registered manager in post however, the provider was in the process of recruiting a new manager.

During this inspection we only looked at the management and auditing of medicines. Therefore we have not reassessed the rating of the service.

People spoken with told us that they were happy in the home and that they received their medicines at regular times. We saw that improvements had been made in the management of medicines so that people received their medicines as prescribed but further improvements were needed particularly in the administration of prescribed creams.

The provider was taking actions to improve staff skills and monitor the competencies of staff administering medicines. A variety of audits were being carried out to monitor the administration of medicines so that shortfalls could be identified and actions taken to prevent re-occurrence of errors.

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

We found that action had been taken to improve the safety of the service.

We saw that people were receiving their medicines as prescribed however improvements were still needed in the administration of prescribed creams.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for safe at the next comprehensive inspection.

Is the service well-led?

Requires Improvement

We found that action had been taken to improve how well led the service was

The provider had systems in place to monitor the administration of medicines but they were not always fully completed and improvements in staff practices were ongoing.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for well led at the next comprehensive inspection.

Briarscroft Residential Care Home

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 last carried out a comprehensive inspection at this service on 27 February 2017. At that inspection we found that there was a breach of regulations because people were not always getting their medicines as prescribed. Following that inspection we issued a Warning Notice to the provider on 13 March 2017.

This inspection took place on 10 May 2017 was unannounced and carried out by two inspectors. The purpose of this inspection was to check that the requirements of the Warning Notice issued on 13 March 2017 had been met. 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.

In preparation for this inspection we looked at the action plan we had received from the provider about the actions they were taking to ensure people received their medicines as prescribed. We spoke with the pharmacist from the Clinical Commissioning Group that supported the service with their medication practices.

During our inspection we spoke with five people and two visitors about the service they received. We spoke with two staff, the compliance development manager, deputy manager and area manager. We looked at the care records of three people and the medicines administration records for fifteen people. We also looked at monitoring records the provider used to check that people were receiving their medicines as prescribed.

Requires Improvement

Is the service safe?

Our findings

We last carried out a comprehensive inspection at this service on 27 February 2017. At that inspection we found that people were not receiving their medicines as prescribed and this meant that their health could be put at risk. Following that inspection we issued a Warning Notice that identified the improvements the provider was required to make by 13 April 2017. The provider sent us an action plan that would be implemented to address the issues we had identified. This follow up inspection was carried out to check whether the provider had made the improvements required and showed that they had.

People spoken with told us they felt safe and happy in the home. One person told us, "I feel safe and content here." We observed that people were comfortable in the presence of staff and staff were responsive to people's needs. People spoken with told us they received their medicines on time. One person told us, "I get my medicines, it's very well organised." We looked at the medicine administration records (MAR) for fifteen people and saw that they had received their medicines as prescribed. We saw that significant improvements had been made to the management of medicines so that people's health was not put at risk due to not receiving their medicines as prescribed. For example, at our last inspection some people had been identified as not receiving their medicines because they were asleep. At this inspection we saw that the incidence of this was much reduced. Instructions were in place for staff to contact the doctor if people were unable to receive their medicines e.g. due to sleeping or refusal for three consecutive days. We saw that no one had been unable to receive their medicines for whatever reason for three consecutive days.

At our last inspection we had identified that some medicines being given to people disguised in food were not being given safely. We saw that the administration of medicines disguised in food had been discussed with the GP and instructions regarding how medicines were to be disguised in food were clear so that staff could administer medicines safely and consistently. Staff spoken with were clear how these medicines were to be given to people.

We had identified at our previous inspection that skin patches used to deliver medicines to manage Parkinson's disease and for pain relief were not always managed well. This was because there was no system in place for recording where patches were placed on the body. This was important so that staff could ensure that the placement of patches was rotated to ensure that people did not suffer ill effects due to placing patches on the same place on the body. At this inspection we saw that there were systems in place to identify where the patch had been applied so that if a patch fell off staff would be aware where it had been placed. Staff needed to ensure that this system was also used where relatives were also involved in administering medicines.

At this inspection we saw that improvement was still needed in ensuring that the application of creams was carried out as prescribed. We looked at cream application charts for six people. We saw that they were not always completed to show that the creams had been applied as prescribed. We saw that some peer audits showed that cream charts had not been checked. The senior management team had identified that this was an area that they needed to address.

We found that although improvements had been made some further improvements were needed. Information received from other professionals involved in monitoring medicines management in the home showed that checks they had carried out had also shown improvements in the management of medicines.

Requires Improvement

Is the service well-led?

Our findings

At this follow up inspection we only looked at the monitoring systems in place for the management of medicines. We have not reviewed the overall rating of this outcome area.

Since our last inspection we had been informed that the registered manager had resigned their post. The compliance development manager told us that the recruitment of a new manager was underway.

We saw that the provider was monitoring the number of medicine errors that had occurred during February, March and April of this year. This showed that following our inspection in February 2017 there was a spike of identified errors in March 2017 due to a heightened awareness of errors occurring. However, we saw that in April there had been a significant decrease in errors suggesting that practices were improving in the home but the timespan did not enable the provider to assess whether the improvements were sustained over a longer period of time.

The compliance manager told us that there had been significant training for staff administering medicines and regular monitoring of medicines administration. We saw that the monitoring of the administration of medicines had been increased and that the management of medicines had improved. There were daily peer audits of medication records to identify missing signatures and to ensure that the medicines had been administered. Any discrepancies were passed to the senior management team so that the discrepancies could be monitored and addressed. We saw that the peer audits did not always identify errors, however, we saw that the senior management team also monitored the quality of the peer audits and were able to identify when this had happened and were then able to take actions. We saw that the provider was taking actions to support individual staff to improve their practice, assess competencies and where appropriate take other actions but this was a work in progress. This meant that the provider was taking the appropriate actions to improve the management of medicines.

Audits were also carried out by staff not working in the home to ensure that there was impartiality in the checks too. This included the Clinical Commissioning Group, the pharmacist providing the medicines, managers from other homes run by the provider, and checks by the provider to ensure the key performance indicators were being met. Systems in place to monitor the administration of medicines showed that there continued to be occasional discrepancies in the audits of medicines but improvements were being made.