Bramcote Nursing Home Limited

Bramcote House Nursing Home

Inspection report

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Ratings

Overall rating for this service

Is the service safe?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 6 and 8 January 2015. Breaches of legal requirements were found. We took action against the provider in relation to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We also found other breaches of regulation when we inspected in January 2015 but we did not follow these up at this focused inspection. We will check to make sure the provider has made the required improvements in relation to those breaches at a later date and report on what we find.

We undertook this focused inspection to check that the provider had made improvements to ensure people received their medicines safely and to confirm that they now met the legal requirement. This report only covers our findings in relation to that requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bramcote House Nursing Home on our website at www.cqc.org.uk.

The service did not have a registered manager in place at the time of our inspection. There had not been a registered manager in post since May 2013. 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.

Improvements had been made in relation to how medicines were managed and administered to people and regular audits were being carried out to ensure this was sustained. People were now receiving their

Summary of findings

medicines as prescribed by their doctor. More improvements were needed in regard to the management of medicines in relation to recording of medicines received into the service and information about medicines which were given on an 'as required' basis.

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?

The service was not consistently safe.

We found that action had been taken to improve the safety of medicines and people now received their medicines as prescribed. Further improvements were needed to the management of medicines in relation to recording of medicines received into the service and information about medicines which were given on a 'as required' basis.

Requires improvement

Bramcote House Nursing Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Bramcote House Nursing Home on 26 February 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 6 and 8 January 2015 inspections had been made. The team inspected the service against one of the five questions we ask about services: is the service safe. We only inspected the safety of medicines. This is because the service was not meeting this legal requirement. We will follow up and report on other improvements we asked the provider to make at a later date.

The inspection was undertaken by two inspectors, one of whom was a pharmacist inspector. During our inspection we spoke with two people who used the service, one relative, three staff and the acting manager. We looked at the medicine records of 16 people who used the service.

Requires improvement

Is the service safe?

Our findings

When we inspected the service on 6 and 8 January 2015 we had concerns that people were not receiving their medicines as prescribed by their doctor. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We took action against the provider by serving a warning notice and told them they must make improvements by 15 February 2015. We found at this inspection that people were receiving their medicines as prescribed but there were further improvements needed in the management of the medicines.

At this inspection we looked at the management of medicines and overall we found that sufficient improvements had been made and the warning notice was met. However, we discussed with the acting manager that although improvements had been made we identified further specific medicine management issues that still required some improvement.

Both people we spoke with told us they were receiving their medicines when they should. One person who we had found previously was not having their ointment applied to support them with a health condition told us staff were supporting them with this now.

When medicines were delivered to the service a record was documented with a staff signature. However, the actual date of the receipt and delivery of the medicines was not recorded. This information is particularly important when checking that people's medicines were delivered and available to give.

Supporting information for staff to safely administer medicines prescribed to be given 'when necessary' or 'as required' was available. However, we found that sometimes specific information was not always documented. For example, we looked at one person who was prescribed a medicine to be given for agitation 'when required'. We found that the supporting information was not specific to the behaviour of the person. Having this information would help to enable staff to make a decision as to when to give the medicine. We further identified that the person had not needed to be given the medicine in four months. We discussed this with the acting manager who agreed to review the need for the medicine with the person's doctor.

Medicines with a short expiry were not always dated when they were opened. In particular we found that external preparations such as creams or ointments were not always dated when opened. This meant there was an increased risk of medicines being used longer than the expiry date and the preparation may no longer be effective. This was discussed with the acting manager who agreed that this should be done.

We observed one nurse giving two people their medicines. The nurse was kind, patient and caring. They explained what each medicine was for and spent time with each person ensuring the medicines were taken correctly and safely.

We looked at people's medicine records, which were signed for the administration of a medicine or a reason was documented to explain why a medicine had not been given. This record therefore showed that people had been given their prescribed medicines.

Medicines were stored within the recommended temperature ranges for safe medicine storage. We saw daily temperature records for both the medicine refrigerator and the medicine storage room which were all within safe temperature ranges.