Anchor Carehomes Limited

# Bloomfield Court

## Inspection report

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27 June 2017

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |
| Is the service safe? | **Requires Improvement** |

# Summary of findings

## Overall summary

Bloomfield Court provides care and support for up to 47 people who may live with dementia and conditions related to old age. At the time of our inspection 44 people lived at the home.

We carried out an announced comprehensive inspection of this service on 21 November 2016. A breach of legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to Regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to unsafe medicine management.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bloomfield Court on our website at www.cqc.org.uk"

Our focused inspection took place on 27 June 2017 and was unannounced.

We found continued failures similar to our previous inspection findings and could therefore not be ensured that medicines were handled safely.

The home had a registered manager who was present at our inspection. 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.

You can see what action we told the provider to take at the back of the full version of the report.

## 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 consistently safe.

Medicine systems were not safe and did not always confirm that people had been given their medicines as they had been prescribed.

We could not improve the rating for the safe question. We will check this during our next planned comprehensive inspection

# Bloomfield Court

**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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. The inspection was carried out by a pharmacist inspector.

We undertook an unannounced focused inspection of Bloomfield Court on 27 June 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection of 21 November 2016 had been made. The team 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 some legal requirements.

We spoke with one person who lived at the home, two care workers and the registered manager. We checked medicine administration records for 14 people. We looked the audit systems in place relating to medicine management.

Requires Improvement

# Is the service safe?

## Our findings

At our previous inspection in November 2016 we found that the provider was in breach of the law as medicines were not managed safely. We carried out this inspection to determine if improvements had been made. However, we identified similar issues and concerns to those we had previously that confirmed that improvement had not been adequately made.

Since our previous inspection there had been a change to the supplying pharmacy which had caused some disruption to the medicine processes but the service had received support from the new pharmacy.

We found that people were not always getting their medicine regularly at night because either the medicine round was taking place too late or because staff failed to ensure that people were given their medicines before they went to bed. Two people had not had their prescribed antibiotics at night because they were asleep which means that their treatment might not be effective and therefore their healthcare condition may not be well managed.

The provider had not made adequate arrangements to ensure that people were getting their medicines as prescribed at a time suitable to their needs. We found gaps on people's Medicine Administration Records [MAR]. This is when there is no staff signature to record the administration of a medicine or a reason documented to explain why the medicine had not been given. Audits on the recording of administration of medicines were being undertaken and any discrepancies were recorded as a medicine incident. These were discussed individually with staff. However, despite the on-going checks there continued to be discrepancies in recording and the safe administration of medicines.

Medicines were available to give to the majority of people however, one person had run out of their pain relief medicine for a period of six days. We were informed that this was because the electronic prescription had not been sent from the GP surgery to the pharmacy. The medicine was made available after six days. We checked the person's daily care notes. The records did not document that the person was in any pain during the six days. We spoke with the person who said that they did not have any pain. Although the person did not suffer any harm the failure to ensure medicines were available means that people could potentially be at risk of harm.

Supporting information for staff to administer medicines was available. When people were prescribed a medicine to be given 'when necessary' or 'as required' there was written information available to support staff to make a decision when to give the medicine. However, for medicines prescribed to be given as a variable dose such as 'Take one or two tablets' we found that the actual amount given was not always recorded. This is important in order to ensure that if another dose is required then staff would be able to determine from the available records whether another dose could safely be given.

We saw that staff that were handling and administering oral medicines had received training and regular competency checks which included members of staff that were applying creams. Records of administration showed that people were getting their cream as prescribed.