Bluebell Residential Home Limited

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Inspection report

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Ratings

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

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service on 5 May 2016. At this inspection we identified a breach of regulation. This was because medication had not been recorded safely. We issued a requirement notice to the registered provider in respect of Regulation 12: Safe care and treatment, with regard to medicine management, as the breach was assessed as having a low impact on people using the service.

We carried out a focused inspection on 20 January 2017 to check whether the registered provider had achieved compliance with the shortfall we identified. This report only covers our findings in relation to the requirement for medicine management. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Bluebell Residential Home Limited on our website at www.cqc.org.uk.

Bluebell Residential Home Limited is registered as a care home without nursing. It offers accommodation and support for 40 older people who may have a physical or sensory impairment or who may be living with dementia. The service is located in Hessle on the outskirts of Hull within the East Riding of Yorkshire. There is car parking on-site and disabled access into the building.

The registered provider is required to have a registered manager in post and on the day of the inspection the manager who was employed at the home was registered with the Care Quality Commission (CQC). 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.

During our focused inspection we found the staff had completed medicine management training in the last year, to ensure they had the skills and knowledge to safely manage and administer medicines to people using the service. Improvements were seen to the recording of medicines on the medication administration sheets.

The service used a risk based approach to people self-administering their medicines. Those people who had capacity and were able to do this safely were supported by the staff to achieve this goal. The risk assessments gave staff clear and precise information on how to reduce the risk of harm to people and there were detailed care plans for medicine management that reflected and recorded each person's ability and support needs.

We saw these changes resulted in the registered provider meeting the breach of Regulation12 in respect of medicine management.

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.

Improvements were seen to the recording of medicines on the medication administration sheets and administration practices. People were kept safe as the registered manager audited the medicines regularly and took action, when needed, to make sure best practice guidance was followed by the staff.

Medicine policies and procedures were reviewed and updated and staff completed medicine management training; this was refreshed on a regular basis.

Risk assessments and care plans on medicine management and self- administered medicines gave staff detailed information about people's needs and the care required to provide them with effective support.

Bluebell Residential Home Limited

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 was meeting the breach of Regulation 12: Safe care and treatment identified at the comprehensive inspection on 5 May 2016.

We undertook a focused inspection of Bluebell Residential Home Limited on 20 January 2017. We inspected the service against one of the five questions we ask about services: is the service safe? This was because the service was not meeting legal requirements in relation to that question when we carried out the comprehensive inspection in May 2016.

The inspection was undertaken by one Adult Social Care (ASC) inspector.

Before our inspection we reviewed the information we held about the service, but we did not request a provider information return (PIR) in preparation for this inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

At this inspection visit to the service we spoke with the registered manager, deputy manager and one senior care staff. We also spoke with one person using the service. This inspection was to look at medicine management practices and record keeping.

We spent time looking at records, which included medication administration record (MAR) charts, one care file and risk assessments for a person who self-administered some of their own medicines, records of staff training and medication audits and action plans.

Good

Is the service safe?

Our findings

At our comprehensive inspection on 5 May 2016 we found there was a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found unsafe practices around the administration and recording of medicines. We looked at a selection of medicine records and we saw evidence that staff were not always signing topical medicine charts (for external medicines) when staff had administered gels, creams and lotions to people using the service. We also found some refrigerated items were not dated when opened. We judged the service impact and risk to people using the service was low and issued the registered provider with a requirement to make improvements.

At the focused inspection carried out on 20 January 2017 we found that the registered provider had made improvements to medicine management and ensured staff followed best practice guidance.

People using the service were able to exercise autonomy around care planning and in their individual care and treatment in relation to the management of risks. We saw that the registered manager discussed people's wishes and choices about self- administrating their medicines, during the pre-admission process. One person who spoke with us said, "It is really important to me that I am able to have some independence over my life. I like to put my own creams on my legs after my shower, but I am happy for the staff to bring me my other medicines and I get these on time and when needed."

We saw that the decision for people to self-administer their own medicines was taken following a risk based approach to care and support. If people had capacity and were assessed as safe and competent to administer their medicines they signed a risk assessment and consent form for this. We noted that people had a lockable drawer in their bedrooms to keep medicines safe. One person told us, "I keep my creams and lotions in a cupboard in my en-suite. I usually stay in my room, but when I leave I lock the door and retain the key so no-one else has access to these items apart from the staff." We saw that this person had a detailed risk assessment and care plan in place for medicine management. It clearly highlighted what they could do for themselves and what support they would need from the staff to maintain their independence. The person using the service had signed the risk assessment and consent form to show they took responsibility for administering their external medicines and agreed to care staff holding their other medicines in safe keeping until they required them.

Improvements had been made to the medicine management practices within the service. We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them, administered by the staff and recorded correctly and disposed of appropriately. The deputy manager informed us that they and other senior staff had received training on the handling of medicines. This was confirmed by our checks of the staff training plan and staff training files.

We looked at how medicines were managed within the service and checked a selection of medication administration records (MARs) and topical medicine charts. We saw no evidence of missing signatures and our random checks of medicines held in stock showed that these were stored appropriately, and the

amount of medicines held matched the records kept by the staff. This indicated that people received their medicines as prescribed.

Controlled drugs (CDs) were regularly audited and stocks recorded accurately. CDs are medicines that are required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001. Medicines that required storage at a low temperature were kept in a medicine fridge and the temperature of this and the medicine room were checked daily and recorded to monitor that medicine was stored at the correct temperature. Any opened items in the medicine fridge were dated on opening and discarded after 28 days to ensure they remained fit for purpose.

The deputy manager told us about how they returned unused and unwanted medicines. There was a return medicines book in place and a container for storing return medicines was in a locked trolley kept for that specific purpose. The pharmacy supplier collected the waste medicines within 72 hours of the staff calling them to request this.

We saw that the medicines policy and procedure had been reviewed and updated in January 2017; it followed the National Institute of Health and Care Excellence (NICE) guidance on best practice with regard to administering medicines within a care service. The registered manager, deputy manager and one of the senior care staff had carried out medicine competency checks of all the staff responsible for administering medicines. These took place throughout 2016 and the documentation was made available to us for inspection.

The deputy manager and senior care staff carried out monthly audits on medicines held in the service and any errors, such as a missing signature, were noted and put onto an action plan. We saw evidence that the registered manager took immediate and appropriate action when errors were found. For example, in November 2016 when the medicine audit showed a discrepancy for one medicine, a safeguarding alert was sent to the local authority and to the Commission. A senior staff meeting was held to go through the medicine procedure and staff competency checks were repeated. New stock balance sheets were introduced for all pain relief medicines and the registered manager and deputy manager carried out weekly stock checks. The registered manager told us that these measures had reduced the number of errors and ensured the risk to people using the service was also reduced. We were shown all the relevant documentation for these actions as part of this inspection.

We saw these changes resulted in the registered provider meeting the breach of Regulation12 in respect of medicine management.