Barchester Healthcare Homes Limited

Stamford Bridge Beaumont

Inspection report

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Ratings

Is the service safe?	Requires improvement

Overall summary

Stamford Bridge Beaumont is a care home which offers nursing and personal care for up to 107 people. The home is situated in Stamford Bridge, which is a village in the East Riding of Yorkshire, close to the City of York. Accommodation is provided over three floors in a Georgian listed building and purpose built extension. The home is divided into five main areas with three of these being used to support people living with dementia. At the time of our visit 84 people were accommodated in the home.

There was a registered manager in post at the time of this inspection who had been registered with the CQC since January 2013. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

We carried out an unannounced comprehensive inspection of this service on 11 & 12 February 2015 when we found the registered provider was breaching one of the essential standards of quality and safety (the regulations) relating to Management of Medicines Regulation 13, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In April 2015 the legislation changed to The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The above breach now corresponds to Regulation 12 (1): Safe care and treatment.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirement in relation to the breach. We undertook a focused inspection on the 20 July 2015 to check that the registered provider had followed their plan and to confirm that they now met legal requirements.

This report only covers our findings in relation to this one breach of legal requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for ‘Stamford Bridge Beaumont’ on our website at www.cqc.org.uk

Summary of findings

At our focused inspection on the 20 July 2015, we found that the provider had followed their action plan in which they had told us they would be compliant by 31 March 2015. We found that sufficient improvements had been made to the way that staff administered and recorded medicines that the level of risk to people who used the service had reduced from a moderate impact to a minor impact. The registered manager had introduced new audit tools and medicine checks to assess and monitor the level of risk, but our observations showed that errors were still occurring and further improvement to staff practice with regard to medicine management was needed.

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

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?

Some aspects of the service were not safe.

Action had been taken to improve the safety of the service. The arrangements for ordering and storing medicines was robust. However, we found that medicines were not always administered safely by staff and recording was not always accurate. There was sufficient improvement to reduce the risk impact on people from a moderate rating to a minor rating.

We will review our rating for safe at the next comprehensive inspection.

Requires improvement

Stamford Bridge Beaumont

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.

This inspection took place on 20 July 2015 and was unannounced. The inspection team consisted of one adult social care inspector from the Care Quality Commission (CQC).

This inspection was completed to check that improvements to meet legal requirements planned by the registered provider after our comprehensive inspection (11 & 12 February 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 legal requirements in relation to that question.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the East Riding of Yorkshire Council (ERYC) Contracts and Monitoring Department and Safeguarding Team. We did not ask the registered provider to submit a provider information return (PIR) prior to the inspection. The PIR is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who receive a service.

During the inspection we spoke with the registered manager, deputy manager, six members of staff and four people who received a service. We observed three different staff administering medicines on three units within the home and looked at 16 medicine administration records (MAR).

Requires improvement

Is the service safe?

Our findings

In February 2015 we carried out an inspection of this service and found that the arrangements for ordering and storing medicines were robust but medicines were not always administered safely by staff and recording was not always accurate.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

At this inspection on 20 July 2015 we saw that the registered provider had followed the action plan they had written following the February 2015 inspection. We found that there remained a breach of Regulation 12 (1). However, sufficient improvement had taken place to move the risk impact rating from moderate to minor for this breach.

People we spoke with who used the service were positive about the care they received but due to communication difficulties as a result of living with dementia they were not always able to tell us whether they received their medicines on time. One person we spoke with, who was in bed, said that they were very happy with the care that they received and the staff were very nice. We observed throughout the day that staff engaged with people when giving their medicines and talked with them about how they were feeling. Observations by staff, of people who found it difficult to communicate, were used to assist in supporting people to take pain relieving medicine.

Staff we spoke with were knowledgeable about the people that they cared for and were able to discuss people's prescribed medicine in detail and any changes that had recently been made. We found in discussions throughout the day that staff were open to talk about issues and they said that the culture created within the home meant that staff reported concerns immediately so that action could be taken. When we spoke with the registered manager and deputy manager they said that they believed that communication between staff had improved and staff raised issues as they arose and discussed them. This meant that potential risks to people who lived in the service from medicine errors were minimised.

We found that staff checked the MAR records and ensured that people had taken their medicines before signing their record. The medicine trolley was kept locked at all times. The registered manager had introduced a new template for staff to record the quantities of medicine which was not supplied in blister packs each time it was administered. Staff said they found the system of counting medicines on every shift positive and the process of discussing any concerns meant that they all shared and learnt from mistakes that had been made and that individual staff were not identified.

We observed medicines being administered on three occasions, by three different staff on three different units within the home. Two were after lunch and one was at tea time. We found that all staff checked the MAR and signed the record once the medicines had been taken. On two units we observed that staff left the medicine trolley in the clinical room which was locked and took the medicines to each person in turn. At tea time the trolley was taken into the lounge area of the unit and was locked at all times when it was left unaccompanied. This meant that there was no risk of anyone accessing the medicine trolley.

We observed that people were given drinks to enable them to take their medicine and that staff remained with people to ensure that the medicine had been swallowed. We saw that some people were given juice and others water, which staff told us was the person's preference. One person was left to take their medicine on their own, but the staff member checked from a distance that the tablets had been taken. The staff member confirmed that this person was capable of taking their own medicine, but staff always observed from a distance to ensure that it had been taken before they signed the MAR.

We observed that staff checked with people whether they required pain relieving medicine where this was prescribed on an 'as required' (PRN) basis. One person was asked by staff if they required pain relief for joint pain and they said that they didn't. When we spoke with the member of staff they explained that this person had a diagnosis of dementia and that the staff observed the way that this person walked and moved so that if they appeared to be in pain they were supported to take appropriate medicine. During the inspection we observed staff asking two other people if they required pain relieving medicine which was prescribed on a PRN basis. This meant that staff checked whether people required pain relieving medicine and also used their observation skills to assess the individual needs of each person.

Since the previous inspection the registered manager had introduced a template to record the quantity of medicine

which was stored in boxes or bottles rather than blister packs. (These are the packs which are made up by the pharmacist with medicine for individual people). The medicine was counted each time it was administered and recorded on this template in addition to the MAR. We observed that on one of these records it was documented that three pain relieving tablets prescribed on a PRN basis had been used, but there was no record of them on the person's MAR. The nurse looked through the MAR sheets for the previous three months to see if they could be traced but there was no record of them having been administered.

We observed the nurse on duty counting tablets for one person. They discovered an error had been made and a tablet which was the same medicine but a different dosage had been given at the incorrect time the previous day. The process in place meant that this error was picked up by the nurse on duty, reported to the registered manager immediately who raised a safeguarding alert. The nurse marked the medicine boxes and the MAR sheet with corresponding coloured stars to highlight the differences in the dosage which was required at different times of the day. This meant that the home had introduced an additional process to minimise the risk of error, action was taken and further measures put in place by the nurse to reduce the risk of this error reoccurring.

We counted one person's medicine and observed that although it had been counted on the morning of the inspection the figure was wrong. When we discussed this with the nurse on duty they re-checked their total and recorded and signed the quantity correctly. They said that as the new process had been introduced and tablets were checked on each shift this meant that this error would have been picked up by colleagues who followed their shift later in the day.

We found that another person had no pain relieving tablets in stock and we saw from the MAR that this medicine had not been taken for some time. Staff had recorded that it was under review with the GP and that pain relieving patches had been discussed as an alternative, but there was no record of the decision to stop the medicine in tablet form. The nurse on duty said that the discussion had taken place and patches had now been prescribed and they faxed the surgery to arrange for this to be documented as soon as possible. We saw that PRN pain relieving medicine was available for required pain relief and the nurse explained that staff identified when this person was in pain as their behaviours changed. This meant that pain relief was available as required and staff monitored the person's behaviour in order to assess whether they required medicine for pain. We noted that a best interest meeting had been held and it was agreed and clearly recorded in their plan of care that medicines could be provided for this person covertly. This meant that medicines were reviewed with the GP when necessary and changes made to meet individual needs.

On another MAR we found that a medicine had been replaced with the same medicine but with a different dose. The dosage on the MAR did not correspond with the dose in the medicine trolley. When we looked at the MAR for the previous day and checked in the records of medicines disposed of during the previous shift and checked the disposed medicines bin, we found that the current medicine had been disposed of rather than the ones which had been discontinued. We discussed this with the nurse on duty who immediately requested a new prescription from the GP. The MAR showed that the person had received the correct dose up their medicine up until the previous day when the tablets had been disposed of.

We saw one example of an unsigned MAR. There was a dot where the medicine had been administered and the nurse on duty had picked this up and had checked that the medicine was not in the blister pack. They said they would discuss this with the person who had been on duty when they were next on shift.

We saw that the pharmacists who supplied the medicines had included a template for staff to sign when they had administered food supplements and we found that these had not always been completed. Where the template was left blank, staff had recorded on the MAR that the supplements had been given or not with an explanatory note at the back of the sheet.

Where pain relieving patches had been administered we observed that they were recorded on the MAR. However, when we looked on the body maps for one person we found that staff had not noted where the patch had been applied; this had occurred approximately one in four times.

We looked at the process for storing and recording the administration of controlled medicine and found that this

complied with the medicine policy. Medicine was stored in a cabinet which was locked twice and two different nurses had the keys which meant that all controlled medicine was administered and recorded by two staff.

We discussed with the nurse on duty people who had specific requirements including a person who had diabetes and required insulin each morning and daily monitoring of their blood sugar. We saw that the records were maintained and signed by the nurses each day. We spoke with the person who told us that they were happy with the support they received and with the staff who looked after them.

We discussed the administration of creams and lotions and saw that these were stored on the nursing units in a separate office from the medicines as they were more accessible for staff. The nurse explained that care staff administered these and reported to the nurse on duty when they had completed their administration and the MAR was then completed. On the residential unit the senior in charge explained that creams were kept in some people's rooms and that there was a risk assessment in place for this.

We talked with the registered manager about drug errors and how these were managed within the home. They showed us the plan produced in relation to each of the recent safeguarding alerts and we saw that actions had been taken. The registered manager explained that the information was shared in Governance meetings where staff discussed the error and what needed to put in place to reduce future risks. Individual issues were discussed with staff on a one to one basis. This meant that a positive atmosphere was created which supported staff to discuss issues and learn from them.

We did not look at training records as part of this inspection but when we talked with staff about their training and development they told us that they received regular updates. One member of staff working on a unit where people had dementia and other mental health issues was a qualified mental health nurse and they were able to describe clearly what different medicines were for and their potential side effects. This meant that people were supported by staff who had knowledge and updated their skills.

This was a breach of Regulations 12 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The service provider had not protected people who used the service against the risks associated with the unsafe use and management of medicines.** Regulation 12 (1)