Place Farm House Residential Home Ltd

Place Farm House

Inspection report

Ladies Mile Road
Brighton
East Sussex
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Tel: 01273563902

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03 November 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We undertook an unannounced focused inspection on 3 November 2016 due to information of concern we had received with regard to medicines management and insufficient heating to keep people warm. We looked at the key question: Is the service safe? This report only covers our findings in relation to this area.

Place Farm House provides accommodation for up to twenty older people, a majority of whom are living with dementia and who may need support with their personal care needs. On the day of our inspection there were sixteen people living at the home. The home is a large property situated in Patcham, East Sussex. It has a large communal lounge, dining conservatory and gardens.

The provider, who also owns another home in the South of England, had taken ownership of the home in September 2016. The management team consisted of a registered manager. A registered manager is a '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 home is run.

People had support with their medicines from trained staff. When asked about their access to medicines, people told us, "We are all well looked after, we get our medicines on time, they're never late" and "They're on the ball they are with that, they've never forgotten it". However, there were concerns with regard to people's access to 'as and when required' medicines. One member of staff, who had not undertaken medication training, worked night shifts on their own. Provisions had been made to ensure other staff, who had undertaken medication training, administered medication in the evening before their shift ended and in the morning when their shift began, so that the member of staff working the night shift did not have to administer medicines. However, for people who required medicines on an 'as and when required' basis at night there were no provisions in place to ensure a suitably qualified member of staff was available to provide these. As a result people may not have had access to medicines when they needed them.

Records showed that there had been a high number of occasions when medication had not been signed for in the Medicine Administration Records (MAR). This raised questions as to whether people had not been given their medicines or if staff had failed to sign the MAR. When asked about the gaps in the MAR the registered manager explained that this had not been recognised. Therefore there was a risk that people had not been given their medicines and that appropriate actions to ensure their well-being, such as contacting their GP, had not been undertaken.

The management of medicines, with regard to ensuring people had access to medicines and that appropriate actions were taken in a timely manner, were areas of concern.

Concerns had been raised that it was not always warm enough in the home. Most people told us that they felt the home was warm and our observations confirmed this. However, some people said that they sometimes felt cold. When asked about the temperature of the building, the registered manager explained that the heating used to be on constantly and that they were now trying to align the inside temperature to

changes in the external temperature. They explained that they were constantly reviewing the temperature in the home and would adjust and increase the temperature if the weather turned colder or if people told them that they were cold.

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 home was not consistently safe.

People received their medicines from staff who had received the necessary training. However, there were concerns with regard to people's access to medicines.

Place Farm House

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 home, and to provide a rating for the home under the Care Act 2014.

We undertook this unannounced focused inspection in light of information of concern we had received with regards to medicines and the temperature of the building. Our inspection enabled us to confirm whether a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had taken place.

The inspection was unannounced, which meant that the registered manager and staff did not know we were coming. The inspection team consisted of one inspector. Prior to the inspection we reviewed the information we held about the home which included information we had received from the local authority. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with eleven people, one relative, one visitor and three members of staff. The registered manager was not at the home during the inspection, however, we were able to speak to them the following day. We reviewed a range of records about people's care with regard to the management of medicines. These included the individual care records for two people, medicine administration records (MAR) for sixteen people and staff training records.

This was the first inspection since the provider had taken ownership of the home.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe and that they received appropriate support with their medicines and were given these on time. One person told us, "We are all well looked after, we get our medicines on time, they're never late". Another person told us, "They're on the ball they are with that, they've never forgotten it". However, despite these positive comments we found areas of practice, in relation to the management of medicines, that required improvement.

People were assisted to take their medicines by staff that had undertaken the necessary training. However, training records for one member of staff showed that they had not yet undertaken medication training. The registered manager had taken appropriate action by ensuring that the member of staff did not administer medicines to people until they had completed their training. However, staff rotas showed that the member of staff had been the only member of staff working for seven night shifts. The registered manager had taken measures to ensure that other staff, who had completed their training in medicines administration, administered medicines to people in the evening, before their shift ended and in the morning when they arrived at work. However, the new member of staff would have been unable to administer medicines to people if they had needed their medicines during the night.

Some people were prescribed 'as and when required' medicines. This means that someone may not regularly need to use these types of medicines, but may need to have them administered if they required them, for example, if they were experiencing pain. Nine people were prescribed 'as and when required' pain relief that could be taken during the night. Records for one person showed that they had required the use of their 'as and when required' pain relief for four nights within a four week period. Another person was prescribed 'as and when required' medicines to reduce their anxiety and distress. Although the registered manager had ensured that staff trained in medicines administration were available to dispense regular night time medicines to people, they had not ensured that there was a suitably qualified member of staff available to ensure people, who sometimes required the use of 'as and when required' medicines, was available during the night. When this was raised with the registered manager, they explained that there were plans to recruit another member of staff, so that there were two members of staff in the building during the night. They explained that until another member of staff was recruited they remained on-call during the night, as they lived nearby. However, there were concerns with regard to people's access to 'as and when required' medicines and the knowledge of staff to identify when people may need additional medicines. This meant that people may not have been able to have access to their medicines when they needed them.

Medicine Administration Records (MAR) showed that there had been 24 occasions, since the provider had taken ownership of the home, when staff had failed to complete the records to confirm that people had taken their medicines. Some of these medicines included anti-depressants, anti-coagulants and pain relief. Not receiving these medicines could potentially have a negative impact on people's well-being. This raised concerns as to whether people had received their medicines, or if staff had failed to accurately complete records in relation to this. When this was raised with the registered manager they explained that this had not been recognised. Therefore, it was unclear whether people had gone without their medicines. The registered manager explained that they had plans to allocate a dedicated member of staff to undertake a monthly

audit on medicines management, and they themselves would complete a more rigorous quarterly audit to recognise any medication errors. However, there were no current provisions to ensure that missed medicines were recognised and the appropriate action taken in a timely way, such as contacting the person's GP for medical advice.

Some medicines require closer regulation because of the harm that can be caused if they are not managed safely. Observations showed that a medicine, which could cause harm or be misused, was not being closely regulated to minimise these risks. The Nursing and Midwifery Council: Standards for Medicines Management, states that there is guidance that advises that it is good practice for healthcare organisations to handle some medicines in the same way as medicines that require closer regulation to ensure a higher level of governance. By not ensuring that this medicine was closely regulated, such as ensuring that there was appropriate storage and recording of its use, there was an increased risk that this could potentially be misused.

The risk of people not receiving medicines when they required them, in addition to the lack of action taken when medicines were missed, was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Concerns had been raised with regard to the building not always being warm enough. The home felt warm and the heating had been set to ensure it was on when people got up in the morning and during the evening. One person was overheard telling staff that they felt cold. Staff immediately provided the person with a cardigan and a blanket and the person told us that they felt warm and were comfortable. Most people told us that they thought that the home was warm. However, one person told us, "They were a bit slow in putting the heating on, it did get very cold". Another person told us, "It is very cold. I go to bed in a dressing gown and it's not comfortable. It's cold here, there is no heating on here sometimes. I don't remember ever having to go to bed with a dressing gown on when I was at home". People told us that it was sometimes cold in the conservatory, which was used as a dining room, and that they had raised this with the registered manager. The registered manager had taken measures to ensure that people had access to additional heat if they required it as they had supplied additional fan heaters for people to use if they required them. When asked about the temperature of the home, the registered manager told us that the heating used to be on constantly, even during warmer weather. They had taken the decision to align the heating with external temperatures and explained that they reviewed the heating on a daily basis and would increase the heating when the weather turned colder or if people told them that they were cold.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment The registered person had not taken the appropriate action to ensure the proper and safe management of medicines.