Barchester Healthcare Homes Limited

Shelburne Lodge

Inspection report

Rutland Street
High Wycombe
Buckinghamshire
HP11 2LJ

Tel: 01494440404
Website: www.barchester.com

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 30 June 2016 and was unannounced.

At our most recent comprehensive inspection on 5 March 2015 we found the service was not fully meeting the requirements of the regulations in place at the time. This was because people had not always been provided with prompt care and support when they needed it, particularly at night. People and staff who cared for them told us a series of management changes had meant the service had not always been consistently well-led. There was a newly appointed registered manager in place who had not, at that stage, been registered by the Care Quality Commission (CQC). Following that inspection we received information of concern about medicines administration and carried out an unannounced, responsive inspection on the 30 June 2015 to assess medicines practice and recording. We also monitored progress made by the service in respect of staffing and the standard of care provided. We found people, including staff, were much more positive about the management of the home. Concerns about staffing at night and response times were significantly reduced. However, in respect of medicines management we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service submitted an action plan on the 5 August 2015 which set out the action to be taken by the 15 August 2015 to address those breaches. The current inspection provided an opportunity to assess if this had been achieved.

Shelburne Lodge is registered to provide nursing care for up to 54 people. At the time of our inspection there were 43 people being cared for.

The service had a registered manager. 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.

We found whilst progress had been made to address previously identified issues about medicines management some areas of concern remained.

People were overall positive about the standard of care they received and the quality of staff. They were less satisfied with the numbers of staff available to meet their care needs at times, when they told us they could experience delays.

Healthcare professionals associated with Shelburne Lodge were positive about progress being made by the service and with the co-operation they received. They in particular felt the management team, led by the registered manager listened to their advice and acted upon it to improve the quality of people's care.

We have recommended the service follows good practice as it applies to the assessment of people's ability

to manage their own medicines.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to the deployment of staff and the management of medicines. You can see what action we told the provider to take at the back of the full version of this 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.

People's medicines were not always managed in line with safe practice.

The numbers and deployment of staff did not consistently ensure people received the care they required at the time they required it.

Risks to people were assessed and kept under review. This meant the risk to people of injury or harm was reduced or eliminated wherever possible.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the Mental Capacity Act 2005 (MCA) were not shown to have been applied to the assessment of people's ability to manage, in whole or in part, their own medicines.

Staff received supervision, support and encouragement to help them maintain and develop their care practice.

People told us the choice and quality of the food provided for them was good.

Is the service caring?

Good

The service was caring.

People were positive about their relationship and the quality of their interaction with staff.

People's dignity was protected and staff treated them with respect.

People were able to express their views about their care and support and how it was provided and they were listened to.

Is the service responsive?

Good

The service was responsive.

There was a detailed care planning process which helped staff provide people's care in the way they wanted them to.

The service responded appropriately when people's needs changed. This ensured their needs continued to be met and that they could remain as independent as possible.

People were able to take part in activities and social events in order to provide them with stimulation and entertainment.

Is the service well-led?

Requires Improvement

The service was well-led with the exception of the monitoring of medicines management.

Staff, relatives and people who used the service were able to talk with the registered manager and senior staff when they needed information, advice or support.

The registered manager and staff worked well with other professionals to ensure peoples' health needs were met.

Shelburne Lodge

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 30 June 2016 and was unannounced. The inspection was carried out by one inspector, two specialist advisors with appropriate backgrounds and experience in medicines and care for older people and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider completed a Provider Information Return (PIR) prior to this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. During the inspection the registered manager was able to discuss this with us. They also provided us with any additional information about the service when we asked and were open and co-operative throughout and following the inspection visit.

We reviewed notifications and other information about the service we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

During the inspection process we contacted 11 health and social care professionals to seek their views about people's care. We received five responses.

During our visit we spoke with 12 people who lived in Shelburne Lodge and also to three relatives of people who lived in the home who were visiting the service. We spoke with the registered manager, the senior member of staff responsible for medicines management and with 10 other staff members including activity staff.

We checked records about how people's care was provided. These included 12 people's care plans and medicines records. We also looked at three staff files containing recruitment checks and details of induction for newer staff and summary supervision and training monitoring records for all staff.

Requires Improvement

Is the service safe?

Our findings

Some of the people who received care expressed concerns to us about the adequacy of staffing numbers. People told us; "They are quite short of staff, breakfast was late so I'm really not hungry now"; "There is not enough staff." One relative told us they thought there were; "Possible staffing issues at meal times for people requiring personal care as there can be delays." Other people were more positive; "I haven't noticed a delay as such. There is usually someone around if I need someone."

Staff we spoke with consistently told us staffing was not always adequate and that this put them under pressure. "We tell them that we are short, but they use the DICE tool (a recognised staffing assessment tool). This does not work." However, they were adamant they ensured people's care needs were met appropriately, despite the pressure they sometimes felt they were under.

Most, but not all of the people who received care said there was no significant difference between their experience during the day and night; "I haven't noticed a difference but I sleep well", "No, I haven't noticed." One person did report; "There are more staff during the day." However, staff told us the staffing at night was not adequate when more than one person who required two care staff to move or turn them, required assistance at the same time.

The provider used a recognised staffing assessment tool to calculate the appropriate number of staffing hours each person required. This took into account the predominant care needs for example; continence, mobility and nutrition, with each domain rated as high, medium or low. This was then translated into an overall number of total hours care and support required to meet those needs effectively. We were told there had been some occasions when staffing had temporarily fallen below the indicated levels, due to short notice of staff absence and lack of available agency cover. We were provided with copies of a random spread of staffing rotas for different parts of the home. We found these did not indicate any chronic understaffing against the assessed level.

Most people we spoke with were satisfied with the standard of care they received; "I feel quite safe", "I feel very safe and the staff are very nice and friendly". One person did tell us; "We certainly don't get the care we used to" and another told us; "I prefer to get up early, but recently it has been quite late. I don't know why." The variations in people's experience of staffing levels and the standard of care could be explained in part by the difference between experienced and longer serving staff and those who were newly recruited.

Where agency staff were required, it was always tried to use those who had previous experience of working at Shelburne Lodge and who were familiar with people who received care and the service's policies and procedures. One health professional noted: "The permanent nursing staff are good, but there are vacancies and there is a high staff turnover, so agency nurses are used. The management try to use the same agency nurses for continuity, but there can be communication breakdown if an agency nurse is on duty during, (for example) the doctor's visit." We were informed that following a request from healthcare professionals, the registered manager had tried to ensure a permanent member of the nursing staff team was on duty for regular visits by the home's GPs.

The CQC were contacted by the family of one resident who had very negative opinions of staff levels and their relative's care. Shelburne Lodge management had been working with the relevant local authority care management team to find a service acceptable to them, better able to meet their relative's needs.

People's inconsistent experience of the adequacy of staffing numbers represented a breach of Regulation 18(1) of the Health and Social Care Act (2008) Regulated Activities 2014 as it refers to the deployment of staff.

We found that significant efforts had been made, since the last inspection, to ensure people were supported and kept safe when their medicines were administered. This included working closely with the service's general practitioner (GP), who sent us comprehensive details of the support they had provided. This included working with a community pharmacist for the local clinical commissioning group (CGC). They assessed; "This had led to the development of a new protocol for ordering, managing and dispensing medicines in a structured, safe way, which has improved things considerably."

In their PIR submitted on the 15 January 2016, the provider informed us there had been four medicines errors in the preceding 12 months.

There was an effective system for ordering and receiving medicines. Received medicines were recorded detailing the date received, name of person, name of medicine and quantity. Used medicines were collected by a specialist contractor for safe disposal and a receipt given.

Medicines administration record sheets (MARS) showed the safe administration of insulin and other medication for the control of type two diabetes. Blood sugar levels were checked and monitored appropriately. Staff showed us the policy on the management of diabetes. People with diabetes had comprehensive care-plans in place to manage their conditions.

People received their medicines at the times they required them and the right dose. We observed the nurse administering medicine. They wore a red tabard with "Do not disturb sign" to ensure they were not disturbed. They took time to carefully read the MARS and then explained to the person what the medicine was for before handing it to them. Where service users had allergies it was recorded on the MARS.

We found some inconsistency with the recording of medicines administration and there were some gaps in recording. In one instance there was no evidence on the MARS chart that the flush prescribed for a percutaneous endoscopic gastrostomy (PEG) had been administered.

Medicine was not always stored appropriately and within the recommended temperature. Medicines that required storage in the fridge were kept in the fridge. The temperature of the fridge was checked daily. The temperature of the fridge had consistently shown temperature above that recommended. There was no daily record of the clinic room temperature. Staff explained "As a result of the problems we had with the recording of room temperature and fridge temperature a new system is now in place". Staff told us; "Problems with the fridge should normally be discussed in the clinical meeting in the morning". These had neither been picked up by the staff and reported in the morning meeting nor by the audit. The staff had not acted in line with the service's policy on what action to take in the event of low or high temperature. By the end of the inspection staff had been in discussion with the pharmacist and the GP. All the medicine in the fridge was discarded and replaced, which represented a significant waste.

We found some poor medicines hygiene. The top of the fridge was dirty and staff promised to deal with this immediately. We also found the medicine cups were washed and left to dry by the sink and some of them still had soap liquid on them.

In the action plan submitted by the provider following the last inspection by CQC, they had noted; "We have implemented a weekly Sunday night check to ensure that we check the expiry dates of all medicines, which we then record". Whilst medicine bottles were appropriately labelled, the dates of opening were not always written on all medicines. An opened bottle of Lactulose solution with no dates of opening belonged to a person who had died. The medicine had not been discarded.

The home had a protocol in place for the dispensing of as required medication (PRN).
Controlled medicines (CD) were ordered and dispensed appropriately. Controlled medicines are medicines which require additional controls because of their potential for abuse. CDs were stored in a locked cupboard within the locked clinic room. There was a CD register. CDs were administered and signed for by two nurses. Staff told us; "The controlled drug is always destroyed by one staff and witnessed by another staff "However, we found one entry which showed that a controlled drug was destroyed, but not witnessed by another nurse.

Sharps were not always managed appropriately. In one instance the lid of one sharps box in use was a quarter full with sharps. The lid was not securely in place and came off easily when picked up. Sharp boxes did not always have dates of assembly and dates of closure or names and signatures of staff as required. During the inspection staff closed the box with date of closure and signature and replaced it with another sharps bin with appropriate labelling. We found there was no poster for sharps injury displayed in the clinic room. Staff told us sharps boxes were collected regularly for disposal.

There was a first aid box in the clinic room. The staff told me that they were purchased about three months ago. The contents were not being checked according to the manufacturer's recommendation.

Staff told us that they had medicines management training and competency tests about a year ago but were unsure about the date. There was no system in place to alert the manager and staff about updating their training and competency. Some of the competency periods had expired. The registered manager arranged to complete one of the competency tests by the end of the inspection.

One person had said they were not being given their medicines by staff. To address this possibility a care-plan had been written with clear instructions that two staff were to witness the administration of medicines. This would be confirmed by the signature of the two staff and the person who received the medicine. These instructions were not followed consistently as we found there had been occasions when only one staff administered the medicines without any witness. The registered manager told us they would ensure the instructions were followed in future.

Whilst we acknowledge efforts made to improve medicines management, the above represent a breach of Regulation 12(1) including Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were risk assessments in place to safeguard people from avoidable harm. These assessments included, for example, pressure care, malnutrition, falls or specific mobility issues.
We found a person who was identified as at a risk of falling from bed had the appropriate risk assessment in place, including the bed rails risk assessment. The care plan detailed the actions required to maintain the person's safety. The bed was fitted with bed rails with protective bumpers to protect them from the risk of entrapment. The records showed that there were hourly checks night and day to provide them with support should they require it. We found the person had their call bell by their side. Staff were aware how to maintain safe use of bed rails. One told us; "We all do bed rails and hoist training as part of our moving and handling training.

We found risk assessments had been reviewed and updated regularly, for example, where there had been changes in people's health. We found staff were able to involve external agencies effectively to help them meet people's assessed needs. For example, there was appropriate involvement of GPs, dieticians and specialist nurses. We received detailed and overall very positive feedback from the healthcare professionals who responded to our requests for information.

Staff confirmed they had received safeguarding training. We saw training records included details of when training had expired or was due. Staff understood safeguarding procedures and told us they were aware of what to do if they saw or suspected abuse.

We found people were protected by appropriate and effective recruitment procedures for staff. We found the pressure on staffing had not led to any decrease in the thoroughness of the recruitment process. Newly recruited staff told us this had been rigorous and we looked at three recruitment records which confirmed this.

We found people were protected from avoidable harm. The provider had plans in place to reduce the effects of any systems or equipment failures and to protect people who lived in the service and staff from harm in the event of a major incident. There were schedules in place for the regular maintenance of equipment and the facilities appeared clean and free from obvious hazards during our inspection.

Requires Improvement

Is the service effective?

Our findings

Overall people received care and support from staff that had the training they needed to do so effectively. The staff team was made up of some very experienced and long serving staff and others who had been more recently recruited. This meant the staff team had a wide range of experience and skill.

The most recently recruited staff told us they had received an effective induction into the service and this was confirmed by the training records we saw. This meant people received care from staff who had the basic skills and understanding required when they began to provide their care and support. However, they had not always been in post long enough to have undertaken significant ongoing or developmental training for example in coping with behaviours that challenge the service. More established staff were overall positive about the level of training they received. They felt they were provided with the necessary skills and knowledge they needed to meet people's needs appropriately. We saw a training matrix which set out training provided and due. One person assessed the training as being 'patient centred' and compared the training they had received since joining Barchester as being a "significant improvement" compared with their previous experience.

People received care from staff that experienced varying degrees of formal supervision. Some confirmed they had regular supervision and appraisal, others seemed less sure. The registered manager provided details of supervisions planned which covered all staff. Staff were positive about the support they received and told us they could approach the management team at any time if they had concerns or wanted advice. We observed there were staff handover meetings at the start of shifts. These provided important opportunities for discussion about people's current care needs and how they were to be met. We also saw minutes of staff team meetings.

Overall we received quite positive assessments from people who received care and their relatives about the quality and competence of staff, as compared to staffing levels. This was not always the case and we had received detailed information from family members who were consistently dissatisfied with the care their relative received. They did confirm they were able to raise these concerns with the registered manager and staff, although they remained dissatisfied with the lack of consistency in the care their relative received.

The majority of relatives we spoke with told us they were kept informed of significant changes with their relative's care needs or situation.

People had access to healthcare services in the community or from visiting healthcare professionals in the service. For example; GPs, dentists, opticians and chiropodists. Details of these appointments and results of any treatment were recorded in people's care plans.

We received mostly very positive feedback from people about food. "Food is good;" "We get a good choice;" "The food is ok and plentiful;" "We have two cooked meals a day which is too much, if I wanted something at night I would just call."

One healthcare professional told us how the home's chef had been supported to; "customise food and enrich it for people at higher risk of weight loss." This had been successful in a number of cases as people had achieved weight gain as a result.

Staff had received training in the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make specific decisions at a specific time. When people are assessed as not having the capacity to make such a decision, a 'best interest' judgement is made involving people who know the person well and appropriate professionals.

Those staff we spoke with understood the implications for their care practice of the MCA. They were aware of how to seek people's consent, using various methods and techniques to assist people, wherever possible to take decisions themselves. However, although the act required that as far as possible people made their own decisions and were helped to do so when necessary; we found this was not consistently applied to all decisions about people's care. We could not find evidence people who might be capable of managing their own medicines were given the opportunity or support to do so. We were told no one was currently self-administering or being supported to self-administer their medicines. A member of the management team told us; "Nobody is on self-medication and if anybody was capable I would have known". A recent audit indicated that competency for assessment of individuals to manage their own medicines was not considered applicable. 'Have individuals been assessed on admission as to their competence to manage their own medication (Not Applicable).'

We spoke to a person who received support with their medicines who said that; "I have not been given the opportunity to take my tablets by myself." In discussion we found they were knowledgeable about the times and frequency they had to take their medicines. There was no assessment in place to indicate the level of support they would require to enable them to be as independent as possible in the management of their medicines.

The registered manager may wish to consider reviewing people's capacity to manage their medicines either in full or in part with support, in order to promote their independence and respect their right to make that decision if they choose to.

The CQC monitors the operation of the DoLS. DoLS provide legal protection for those people who are or may become deprived of their liberty or to have their liberty restricted. In their PIR the service reported that 22 people had their liberty, rights or choices restricted in some way in the way their care was provided. We looked at sample records and found mental capacity assessments and deprivation of liberty safeguard applications had been completed appropriately.
The premises were well-maintained. Communal areas and individual bedrooms were well-designed and provided people with a pleasant and safe environment in which to live. People had access to the equipment they required to assist them in daily living and hoists and assisted baths were maintained appropriately. This showed the premises were designed and maintained in order to meet the needs of people who had, for example, limited mobility.

Good

Is the service caring?

Our findings

People were positive about their relationship with and the quality of their interaction with staff. "I can't express how good they are. I have a new lease of life." "I am very comfortable here, staff are pretty good" were some people's comments.

We observed care throughout the day, including over lunch in different parts of the service. The interactions we saw were positive. For example, we saw one person was missing their dentures, staff ensured her dentures were found, cleaned and fitted in place. We observed staff were respectful, compassionate and proactive in the way they supported people. A healthcare professional told us; "The permanent staff generally seem caring and show concern for the residents' welfare…some show outstanding caring and are always able to tell me about a resident's health, specifically concerning their well-being, including oral intake, bodily functions and the state of their skin."

People told us they were able to express their views about their care and support and how it was provided. They said they were involved in decisions about their care to the extent they wanted to be. They told us they were able to change their routines if they wanted to do so, for example when they got up and where they ate their meals. The care plans we saw had variable levels of detail about the active involvement of people in their care although all had some at least. When asked if they were supported to maintain their independence, answers ranged from; "yes;" "as much as is possible;" and "to a degree" to "no I don't think so."

Staff had received training in end of life care. A healthcare professional who had recently been involved with Shelburne Lodge was very positive about staff knowledge and understanding of people's needs and how they could be sensitively and effectively met at the end of their lives. This ensured people's care at the end of their lives was effective and appropriate, including the management of pain. A number of people we had conversations with confirmed they had discussed resuscitation with their relatives and had appropriate documentation in place reflecting the decisions they had made.

There were details of advocacy services available to people in the home. People had access to advocacy services when they needed them. Advocates are people independent of the service who help people make decisions about their care and promote their rights. This meant people who needed support to express their point of view about their care and support were able to access independent help to achieve this. In most cases we were told, people either self-advocated or family and/or friends advocated on their behalf.

In their PIR the provider confirmed they had equality and diversity policies and procedures in place and staff we spoke with understood the importance of these and how to treat people as individuals irrespective of ethnicity, gender, sexual orientation or their physical or mental ability. The staff team was not overall representative of the people they provided care and support for. However, this was not raised as an issue with CQC by either the people themselves or their relatives, although we were told by some people that they had difficulty in understanding staff where English was not their first language. "Some staff have language issues – but we get by."

Good

Is the service responsive?

Our findings

We looked at 12 care plans. The standard of completion varied between the best examples seen and those with gaps or where the information was not always up to date. Care plans were arranged with an index and sections. They showed that people were assessed prior to moving into Shelburne Lodge. One of the staff told me that "we used this information to maintain continuity and develop our own care plan". The care plans were detailed, but did not always indicate the involvement of the person concerned and/or relatives. Care plans were regularly reviewed and they had guidance notes for staff to follow.

Where care plans were fully completed we found they gave the information care and nursing staff required to provide care and treatment focussed on the individual and taking their wishes and preferences into account. This included, mental capacity assessments, advanced care plans, and in most cases past medical history and allergies. In general, appropriate risk assessments and their reviews had been completed and undertaken. People's weight was recorded monthly and regularly and more often in the case of people at risk of malnutrition. A recognised tool was used to monitor people's risk and these were monitored monthly. When necessary people were referred to dieticians and Speech and Language Therapist (SALT) when they had difficulty in swallowing. There were diabetic monitoring charts, however again we found there were gaps in the recording.

There were appropriate assessment and care plans in place to manage incontinence. There were regular checks recorded and there was also a regular daily catheter checklist.

The notes showed that people had the input from other healthcare professionals in order to meet their healthcare needs, for example GP, dentists, physiotherapist, dietician, diabetic nurse, district nurse, chiropodist and optician. Their input and intervention were recorded in care plans. Information we received from a range of healthcare specialist involved with Shelburne Lodge during our inspection, indicated the service was prepared to involve and follow the advice of specialist external support. This meant people benefitted from the specific expertise needed to meet their more complex needs.

In some cases we found the 'life history' of people who received care was not always readily accessible. This was because people or their relatives had not provided it, or it was not very detailed. Where information could not be found or was not available it was harder for staff to reflect the individual's past history, interests and wishes in the practical, day to day provision of their care. However, we found when we spoke with longer serving staff that knew the way people liked their care provided and sought to meet their wishes.

We spoke with one of the activities co-ordinators. They provided details of a typical activity programme and some of the events that had taken place. They confirmed they had input into care plans by including an activity plan within them. People we spoke with were quite positive about the activities and we observed activity sessions during our visit. The programme included trips out of the service, external entertainers as well as one to one sessions with people in their own rooms.

Systems were in place to manage complaints and concerns. We were included before, during and after the

inspection in e-mail correspondence between relatives and the home's registered manager. There was a formal complaints procedure clearly available within the home, which included contact details for the CQC and other appropriate bodies. Complaints were recorded and the outcomes noted. The majority of people or relatives we spoke with indicated they would approach staff and the management of the service informally in most cases rather than raise an official complaint. It was the case that not all complainants were satisfied with the outcome of their complaints. In those cases details were available as to how their complaints could be taken further, for example to the appropriate ombudsman.

Requires Improvement

Is the service well-led?

Our findings

People who lived in Shelburne Lodge were, in the main, supportive of the registered manager and their team. Some relatives were very critical of the management team based on their experience over several months. Other relatives told us they thought the current stability of manager had been helpful for them and had enabled the service to; "Settle down". One healthcare professional's assessment was that the service was now well-led. They said the registered manager took advice and acted on it and both registered manager and deputy manager maintained good communication with them, which benefitted people living in Shelburne Lodge.

We received very full and effective co-operation from the registered manager throughout the duration of the inspection, prior to as well as following our visit. The registered manager displayed openness and candour in terms of the information provided to CQC and during discussions with them during the inspection and afterwards when they responded promptly to any requests for information or clarification.

Staff confirmed they had meetings with managers at all levels and that the registered manager was visible throughout the service on a daily basis. There were regular meetings with the senior staff and the registered manager. We were provided with minutes of a range of team and specific focus meetings, for example on falls and nutrition.

In their PIR, the registered manager reported they had; 'recently appointed a deputy manager alongside the established head of unit giving the home a stable management structure.' This benefitted people who lived in Shelburne Lodge and their relatives, who could build better relationships with the management team over time.

Staff told us there was an open door policy and visibility of the senior team. They told us they would not hesitate to take any concerns they had to the management team, including the registered manager. We were told there was a daily head of department meeting where all departments of the home met to discuss issues arising for the previous day and planning for the day ahead.

The service had a statement about the vision and values it promoted; these were displayed in the home. Throughout our visit we saw staff consistently treated people with dignity, respect and compassion. The home had good links with the local community, such as local schools and visiting clergy.

There was a quarterly manager's quality assurance tool which was in place which comprehensively captured all areas of the homes operation in detail. These measures and systems confirmed the operation of all areas of the home's activity were being monitored. Monthly quality assurance monitoring was in place. External regional managers visit and carry out audits in the home. However, the monitoring which was in place, had failed to identify and rectify issues with medicines management identified in this report. This was despite the fact this had been raised following the previous inspection and had been the subject of the service's own action plan.

The rating of requires improvement reflects the concerns raised in this report which have not yet been fully addressed.

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 Medicines were not appropriately stored. Appropriate arrangements were not in place to check the expiry dates of medicines. The accuracy of medicines records were not effectively monitored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not always effectively deployed to meet the needs of people using the service at all times.