Barchester Healthcare Homes Limited

Shelburne Lodge

Inspection report

Rutland Street
High Wycombe
Buckinghamshire
HP11 2LJ
Tel: 01494 440404
Website: www.barchester.com

Date of inspection visit: 30 June 2015
Date of publication: 23/09/2015

Ratings

Overall rating for this service

Is the service safe?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of Shelburne Lodge on the 5 March 2015. We found people had not always been provided with prompt care and support when they needed it, particularly at night. People told us they felt safe and secure and were positive about the standard of care received, more so during the day than at night. There was a newly appointed manager in place who had not at that stage been registered by the Care Quality Commission (CQC), although an application to do so was in progress. People told us they were looking forward to a period of sustained stability in the home's management following a series of management changes.

Following that inspection we received information of concern about medicines administration and associated care practice. This focussed inspection was carried out to assess medicines practice and recording. We also monitored progress made by the service since our previous inspection in respect of staffing and the standard of care provided. This report only covers our assessment of whether services at this location were safe.

Shelburne Lodge provides residential, nursing, respite, palliative care and accommodation for up to 54 people. The home provides care for older people, including those living with dementia and younger adults, including people with a physical disability or sensory impairment. At the time of our inspection there were 41 people living at the home.

The manager for the home had made an application for registration with the CQC which was still under consideration. They were being supported by a senior Barchester Healthcare Homes manager who was present during this inspection visit.

During this visit we found people, including staff, were much more positive about the management of the home.

Summary of findings

There were still some concerns about response times, but less than previously. Some staff still felt that at times they were under too much pressure and weren't always able to provide care in the way they would ideally like to.

In respect of the safe management of medicines we found the service was not consistently safe. Medicines were not appropriately stored, appropriate arrangements were not in place to check the expiry dates of medicines and the effectiveness of medicines were not appropriately monitored. Medicines were kept within their recommended temperature ranges, safely administered and recorded.

We found breaches of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of this report.

You can read the report from our last comprehensive inspection in March 2015 by selecting the, 'all reports' link for Shelburne Lodge on our website at www.cqc.org.uk

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?

The service was not consistently safe.

The provider did not have appropriate arrangements in place to manage people's medicines safely.

People were conscious of pressures on staff and staff felt at times they were not able to provide care in the way they would ideally like to.

People told us they felt safe. They were in most cases positive about the standard of care they received and were increasingly positive about the way the home was managed to maintain their safety.

Requires improvement

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 2015 and was unannounced.

The inspection was carried out in response to concerns raised with the Care Quality Commission about medicines practice and to follow up concerns identified during our previous inspection of March 2015.

The inspection was carried out by two inspectors one of whom was a pharmacist inspector for the Care Quality Commission.

We reviewed any information received about or from the service since our inspection in March 2015, including the concerns raised with us about medicines practice.

During our inspection we spoke with the regional manager for Barchester Healthcare Homes Limited responsible for oversight of Shelburne Lodge and with the recently appointed manager for the service, who was in the process of registering with CQC.

We spoke with six people who live in Shelburne Lodge and with eight relatives. We spoke with one nurse and two care staff from the night staff team and with two nurses and four care staff from the day staff team. We also spoke with the financial administrator and the activity co-ordinator.

We looked at nine care plans, 18 medicines administration records and three body maps. During the course of the inspection we observed care in one of the lounges for a period of one hour.

During or shortly after the inspection we were provided with minutes of staff and relative's meetings, audit documentation and staffing records. We also saw minutes of recent meetings held with specific staff to review skincare, nutrition and falls and a copy of a typical activity programme.

Requires improvement

Is the service safe?

Our findings

The service was not consistently safe.

Medicines were not appropriately stored. Whilst medicines were stored within their recommended temperature ranges and most medicines were stored securely, we found one Controlled Drug was not stored within the Controlled Drugs safe (A controlled drug is a medicine which requires more secure storage, by law). We also found food belonging to a member of staff within the medicines refrigerator.

Appropriate arrangements were not in place to check the expiry dates of medicines. Whilst the date of opening was recorded on eye drops, liquid medicines and an inhaler; a bottle of eye drops and an inhaler had not been removed from use although they had expired.

The effectiveness of medicines was not appropriately monitored. We reviewed five resident's records who were prescribed one of two medicines that required monitoring. Whilst test results, dose changes and subsequent tests were scheduled for three residents prescribed one drug, only the dose was recorded for the two residents prescribed the other medicine. One resident had medication to treat a potential anaphylactic reaction; however, their records lacked a relevant care plan. Whilst a further two residents had breathing care plans, these lacked details of the prescribed "when required" inhalers.

This was a breach of Regulation 12(1) including Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The administration of medicines was appropriately recorded via Medicine Administration Records (MAR) including medicines related tasks like cleaning the oxygen concentrator filters. Where medication doses or frequencies had changed mid-cycle, one nurse would amend the MAR also recording the date of the change. A second nurse would then check and countersign the MAR, documentation to support these changes from discharge summaries or visiting healthcare professionals advice which were available within the care plans. A care worker explained how they applied creams to the residents as part of their personal care. The care worker showed us the records they kept. The administration records and creaming plans reflected the frequency of creaming described by the care worker.

Information was available to support the administration of medicines. Information on, allergies, "if required", "variable dose" and if the resident was aware of their needs and could request medicines were documented.

We saw minutes of recent staff and relative's meetings. The former had included discussion of changes to medicines records procedures following a recent medicines error. This had led to a review of the system used to document and monitor medicines brought into the home when people returned from hospital or were brought in by families.

The community pharmacy used by the service had recently undertaken a medicines audit; which we were shown. Between the audit and receiving a written copy of the report, the service had implemented a number of changes. Staff had also undertaken internal audits during April and June that had identified a few of the concerns we have reported like monitoring the effectiveness of medicines.

We spoke with both night and day care and nursing staff. Overall they told us they felt the management of the service had improved with the new manager and a period of greater consistency. Staff still felt at times they were under too much pressure; "It can be hard at times" we were told when speaking with three staff members. As was the case with our previous inspection some of the relatives we spoke with thought staffing was inadequate at times whilst others said it had improved with the reduction in the use of agency staff. Again, on balance, relatives said the new management had been an improvement, although one relative said they still intended moving their relative to an alternative service.

We checked staffing rotas for a number of different shifts on different days. We looked at signing in records for both permanent and agency staff. We found that on all but a very few occasions staffing had been at the set level. We were told problems usually only arose when staff gave very late notification of not being able to work. It was noticeable that the use of agency staff had decreased over the past month and that where agency staff were used, they were very familiar with the service and the people who lived there. This gave people more consistent care and support. "It is much better now there are no agency staff" was one relative's comment.

Our observations throughout the inspection showed people were being engaged and their care monitored. When we looked at the care records for one person who

Requires improvement

Is the service safe?

had appeared not to be effectively engaged by staff whilst we were observing them, we found very clear information about their wish to be left alone documented. During our inspection there were no instances when call bells were not responded to in a reasonable time. Meal times benefitted from those family members who offered additional support to staff in assisting people to eat and drink.

The manager and regional manager confirmed staffing levels were still kept under review and would be increased when occupancy rose.

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	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 effectiveness of medicines was not appropriately monitored.