Bupa Care Homes (GL) Limited

The Highgate Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
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 31 May and 1 June 2017 and was unannounced. The Highgate Care Home provides accommodation for 52 people who require nursing and personal care. On the day of our inspection there were 49 people using the service. The home was set out across four floors; of which the lower ground floor had 10 bedrooms, ground floor had 13 bedrooms, first floor had 16 bedrooms and second floor had 13 bedrooms.

There was a registered manager in post. 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 last inspected this service in April and May 2015 and the service was rated as 'Good'.

At this inspection we identified concerns with how the service managed medicines. Medicines were not being managed safely. We found five instances of where people were not administered their prescribed medicines despite nursing staff having recorded that they had. 'As needed' or 'loose' medicines were not consistently monitored to assure accurate stock levels.

People and relatives that we spoke with highlighted concerns around the low staffing levels within the home. Appropriate level of need assessments had been completed, which determined the staffing levels. We observed there to be sufficient staff available to support people.

Risks associated with people's care and support needs had been identified and these had been assessed giving staff instructions and directions on how to safely manage those risks.

People told us they felt safe. Procedures and policies relating to safeguarding people from harm were in place and accessible to staff. All staff had completed training in safeguarding adults and demonstrated an understanding of the types of abuse to look out for and how to raise safeguarding concerns.

Appropriate checks had been made to ensure the premises were safe.

We saw evidence of a comprehensive staff induction and on-going training programme. Staff had regular supervisions and annual appraisals. Staff were safely recruited with necessary pre-employment checks carried out.

People were given choices during meal times and their needs and preferences were taken into account. Nutritional assessments were in place, which included the type of food people liked and disliked. People's weight was recorded regularly and action was taken should people lose weight significantly.

The registered manager and staff demonstrated a good level of understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager had submitted applications to the local safeguarding authority for each person who required an authorisation to ensure that people were legally being deprived of their liberty which was in their best interest.

We observed caring and friendly interactions between management, staff and people who used the service and people spoke positively of staff and management.

A complaints procedure was in place which was displayed for people and relatives. There was an incident and accident procedure in place which staff knew and understood.

Staff, residents and relatives meetings were held regularly and surveys were completed by people and relatives.

People, relatives and staff spoke positively of the current management team. Quality assurance processes were in place to monitor the quality of care delivered.

We identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach related to safe medicines management. You can see what action we told the provider to take at the back of the full version of the 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 always safe. Medicines were not always administered, recorded or monitored safely.

There were sufficient staff to ensure that people's needs were met. There was a robust recruitment procedure in place.

Risks to people who used the service were identified and managed effectively.

Staff were aware of different types of abuse, how to identify abuse and what steps they would take if they had safeguarding concerns.

Is the service effective?

Good

The service was effective. Staff had access to regular training, supervisions and appraisals which supported them to carry out their role.

People were provided with sufficient food and drink. Where people were at risk of dehydration or malnutrition, measures were in place to monitor their intake.

People were given the assistance they required to access healthcare services and maintain good health.

Staff understood the Mental Capacity Act 2005 and principles of the code of practice were being followed.

Is the service caring?

Good

The service was caring. We observed positive relationships between staff and people using the service. Staff treated people with respect and dignity.

Staff had a good knowledge and understanding of people's backgrounds and preferences.

Is the service responsive?

Good

The service was responsive. Care plans were detailed and person

centred.

We received positive feedback from health professionals regarding the responsiveness and initiative of the service when people's care needs changed.

The home had a complaints policy in place and people and relatives knew how to complain if they needed to.

Is the service well-led?

Requires Improvement 

The service was not always well led. The provider had a comprehensive system for monitoring the quality of care with regular audits and action taken where necessary. However, although these audits had identified some of the issues we found with medicines management during the inspection, sufficient improvements had not been made.

There was a clear management structure in place and people and staff spoke positively of the registered manager and deputy manager.

The service worked well with health professionals and local hospitals.

The Highgate Care Home

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 checked 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 31 May and 1 June 2017 and was unannounced.

This inspection was carried out by two inspectors, an assistant inspector and an expert by experience who spoke to people and visitors and made observations throughout the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection, we reviewed the information that we held about the service and the providers including notifications affecting the safety and well-being of people who used the service and safeguarding information received by us. We reviewed the Provider Information Return (PIR) which the provider had sent to us. A PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We received feedback from a local placing authority.

During the inspection we obtained feedback from ten people and 14 relatives. We spoke with the registered manager, four registered nurses, seven healthcare assistants and the head cook and housekeeper. We spoke with two visiting healthcare professionals.

We looked at eight people's care files and risk assessments, daily records, 11 staff files, staffing rotas and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us that they generally felt safe living at The Highgate Care Home and felt safe when supported by the care staff. Comments received from people included, "Yes I do feel safe. The security here is exceptional and you can talk to the manager directly", "Yes I do feel safe here" and "I've been here for five years. Yes I do feel safe." A relatives told us, "Yes, very safe here." However, despite this positive feedback there were some aspects of the service that were not safe.

We checked how medicines were managed at the service. We observed one medicine round and spoke to nursing staff and the home management team regarding medicines management. We also looked at audits and training records in relations to medicines management. Medicines were not being managed safely and people were being put at risk of harm.

Some people were not receiving their medicines as prescribed. There were instances where people missed doses of their medicines, however nursing staff recorded in the person's Medicine Administration Record (MAR) that their medicines had been administered. We found five instances of where this type of medicine error occurred within the current medicines cycle at the time of the inspection.

When medicines were prescribed to be given 'only when needed', or where they were to be used only under specific circumstances, individual when required protocols were in place. These protocols informed staff about when these medicines should and should not be given. However, we found that where these medicines were stored as 'loose medicines' in a box, nursing staff were not consistently recording stock levels as and when these medicines were administered.

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

We saw medicine was stored securely. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature. Controlled drugs were stored and managed appropriately. Controlled drugs are medicines that the law requires are stored, administered and disposed of by following the Misuse of Drugs Act 1971.

We observed nursing staff engage with people in a kind and caring manner during the medicines round. We observed nursing staff ask people if they required pain relief.
Records confirmed that nursing staff had received medicines training and were assessed on a regular basis by the deputy manager at the home. Medicines management were also discussed in supervisions and clinical meetings.

Risks associated with people's care and support needs had been identified and these had been assessed, giving staff instructions and directions on how to safely manage those risks. Risk management plans were specific to the individual and were clear and evidence based. These included falls, manual handling, skin care, mental health, malnutrition universal screening tool (MUST) and Waterlow, a pressure area risk

assessment chart. We saw that where a person was on a blood thinning drug, this was noted on their skin care risk assessment as it could affect the person's skin integrity. On another person's risk assessment, we saw signs that staff should be aware if the person was suffering from mental ill-health.

Staff knew how to keep people safe. Staff had all received safeguarding training as part of their induction and ongoing training. Staff we spoke with were able to tell us about types of potential abuse and how to report any allegations. They spoke highly of the training they received in relation to safeguarding and said they would report all concerns to their senior or the registered manager. They told us they were confident that the responses of managers when they reported any allegations or concerns would be supportive. Staff understood how to whistle blow and could tell us the escalation process, including how to contact the Care Quality Commission.

We looked at 11 staff records and saw there was a safe and robust recruitment process in place. Staff files showed that the relevant checks had taken place before a staff member commenced their employment. We saw completed application forms which included references to their previous health and social care experience, their qualifications, employment history and explanations for any breaks in employment. We saw a list of all staff which confirmed that each staff member had an in-date Disclosure and Barring Service certificate (DBS). This meant they were considered safe to work with people who used the service. Records included interview notes and two employment references. Where there had been a delay in references being returned, we saw evidence of this being pursued by office staff. Staff files contained a copy of the staff member's passport and where relevant, confirmation of their right to work in the UK. All records relating to nursing staff were maintained and included their up to date PIN number which confirmed their professional registration with the Nursing and Midwifery Council (NMC). Their revalidation date was also recorded.

We received a mixed response from people and relatives when asked if staffing levels were sufficient. Comments from people who used the service included, "No, they could do with increasing staff by about two on every floor", "Possibly [staffing] is just right" and "Not enough during the day; they need one more person." We received similar feedback from relatives and comments received included, "Yes, there's always someone to ask for anything; I don't know how many [staff] there are", "Yeah but maybe at weekends less so [enough staff]" and "At times, no [to enough staff]."

Overall, there were sufficient numbers of suitably qualified staff to keep people safe and meet their needs. Staff we spoke with told us that there was never a feeling of being rushed in their work provided the full staffing compliment was on duty, "I feel I can really do my work properly and spend quality time with our residents." Our observations during the course of the inspection were that we did not see staff rushing around and they were able to respond quickly to requests from those who used the service. However, we observed throughout the inspection staff at times congregated in groups to take their breaks and have discussions which impacted on the availability of visible staff on the floors which was mentioned in feedback we received from some relatives. We brought this to the attention of the registered manager who advised that a certain number of staff should take their breaks at certain times to ensure a sufficient number of staff were available on the floors.

The registered manager told us that she used an assessment tool to gauge staffing levels each week. This was calculated in relation to the assessed needs of those who used the service to ensure their needs were adequately met. The registered manager told us her priority was to ensure that people were safe and staff had sufficient time to meet their needs without feeling rushed.

We asked people if their call bells were responded to in a timely manner. We received a mixed response. One person told us, "Yes, they're quick to respond to the call bell, usually one or two minutes." A second person

told us, "I don't have long to wait for the (call) bell" and a third person told us, "I understand that sometimes I have to wait for the bell to be answered." We saw that call bell response times were monitored, analysed and were generally answered within five minutes. Where there was an anomaly to this, the reasons were investigated and addressed.

Accidents and incidents were recorded and actions and learning identified as a result of the incident were implemented. Staff knew how to report accidents and incidents.

The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting and gas and electrical safety were undertaken.

The home was clean and we saw it being cleaned throughout the day. The home smelt clean and fresh at all times during the inspection. Infection control measures were in place and we saw staff using gloves and protective clothing appropriately. Staff we spoke with told us they had done infection control training which helped them to understand the importance of being careful for everybody's safety.

We saw there was a Personal Emergency Evacuation Plan (PEEP) on each record, specific to the individual's needs. They outlined how the person should be evacuated for example, where a person was bed bound; their plan specified that they required full horizontal evacuation.

Good

Is the service effective?

Our findings

People and their relatives were generally positive about staff and told us they were skilled to meet their needs. Feedback received noted particular care staff who people and relatives said were particularly responsive. Comments received from people included, "They are kind and efficient; everything you could ask for", "Not all of them. I'd say about 25% of them [staff] need to be re-trained" and "The carers are fine". A relative commented, "They're very nice and good and they know what they are doing. They check on her a lot and keep everything very clean and tidy." A second relative commented, "I would say they have been trained adequately."

There was a comprehensive induction programme which all new staff had to complete. Staff we spoke with told us they went to another home for one week of classroom work and then returned to observe care and shadow more experienced care workers until such time as they were assessed as competent to work alone. One care worker said this helped them to "understand people's individual needs" and gave them confidence in their work. Another staff member told us "I felt so much more confident and I knew I could do my job well and safely after the induction process."

Staff told us they had completed training in a number of areas including safeguarding adults and Mental Capacity Act, infection control, nutrition and hydration, and manual handling. They said they were given lots of opportunities to attend training in areas that reflected the needs of the people. We saw evidence of additional training done by nursing staff such as syringe driver, dysphagia, catheterisation and MUST (Malnutrition Universal Screening Tool). Staff felt they had received enough training to provide people with effective care. They spoke positively of the training which was provided. They said this was done in-house and usually face to face. They also told us they were not expected to come in on their days off to train.

Staff talked to us about the support and supervision they received. They said they felt well supported within the home and that there was always someone to go to for advice. The provider had recently introduced a new form of supervision and appraisal, 'goals, development and conversations'. The registered manager told us this gave a framework to supervision, and included a goal setting meeting, four other meetings during the year and an end of year review or appraisal. We saw some examples of this style of supervision and saw there was an expectation that staff engaged with the process in order to maximise the benefits and aid their development.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was

working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people were deprived of their liberty the registered manager had made appropriate applications to the local authority for DoLS assessments to be considered for authorisation.

Training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty and Safeguarding (DoLS) had been provided and staff clearly understood the importance of seeking people's consent and offering them choice about the care they received. Where people lacked capacity to make some decisions, staff were clear about their responsibilities to follow the principles of the MCA when making decisions for people in their best interests.

We received mostly positive feedback from people and relatives regarding the standard of food and choices available. Comments from people included, "You get a choice of between one or two [food options]. I like the choices I make", "The food is good. You would never starve", "The food is very good and you get three or four choices or you can request something light, like an omelette" and "You do get a choice. It's all right." A relative told us, "She seems to have a choice but it's always the same stuff."

We discussed people's dietary needs with the chef. They explained how they received information from nursing staff and provided soft, pureed or fortified meals as instructed. We saw this information was added to the sheet which care workers used to obtain people's food choices. We spoke with catering staff who demonstrated an understanding of people's individual dietary needs. The chef told us they ensured they had culturally specific foods in at all times. They also told us people could make requests in addition to what was on the menu. For example, we observed a person requesting and being provided with steak for lunch. They also showed us a special cereal which one person was particularly fond of.

We saw that food was appropriately stored in fridges and was wrapped and dated. We also looked at records of all checks carried out on a daily basis, including temperatures of fridges and freezers and temperatures of food served. We saw that all areas of this had been signed as completed on a regular basis. There was a plentiful supply of fresh and frozen food, including fruit, vegetables and dry stores.

We observed lunchtime on both days of the inspection and saw that most people chose to eat their meal in their bedrooms. Our observations during the inspection were that food was well presented and looked and smelt appetising. We observed kind and caring interactions when people were being supported to eat in their bedrooms and all people received their meals in a timely manner. Where people ate their meals in the communal areas, we saw that some care staff engaged with people in a caring and jovial manner and we observed that some care staff ate their meals with people who used the service.

Relatives were able to visit at lunchtime and support their own relative with their meal and people were encouraged to sit next to each other so that they could socialise with each other. There were a variety of drinks and snacks available on the units from which people were able to choose what they wanted. We also saw that drinks were available in people's rooms.

There were systems in place to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were assessed using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults were malnourished or at risk or malnutrition. We saw evidence that, where a risk was identified, a care plan was implemented in order to manage this risk. The MUST was reviewed on a regular basis and people had regular weight checks. Weight loss was recorded and referrals were made to a dietician in a timely manner.

People were supported to maintain good health and had access to a variety of healthcare services which included GP's, opticians, chiropodists, physiotherapists, psychiatrists and tissue viability nurses. We also saw evidence that following appointments, people's care plans were updated accordingly. A visiting health professional gave us positive feedback regarding their experience of working with the service.

Good

Is the service caring?

Our findings

We asked people if they felt that staff were kind and caring. Feedback was positive and comments received included, "I like it here. People are very kind and friendly", "Yes and some are better than others with anticipating your needs" and "I'd rate them about eight or nine out of ten." We received similar feedback from relatives and comments received included, "The staff and the nurses are very kind here" and "Yes and it's not just a job, it's like they're being friends. It's not an atmosphere of gloom here."

During the inspection, we observed interactions between staff and people living in the home. People were relaxed with staff. Some staff interacted positively with people, showing them kindness, patience and respect. We observed some staff sitting chatting to people and saw another staff member eat their lunch in a person's room. We observed that people had a genuine fondness for some staff members, for example a person and a relative presented a member of staff with flowers for their birthday and we observed people enthusiastically welcome back another staff member who had been on holidays. We also observed this staff member go around and introduce herself to people recently admitted to the home who had not met her before.

Staff we spoke with had a good understanding of people's individual backgrounds, ages, likes and dislikes. People were addressed by the staff using their preferred names. Staff told us they had read peoples care plans. We observed a conversation between a person and a staff member where they discussed pie and mash shops the person frequented when they were younger. The person appeared to enjoy reminiscing about their childhood and local area with the staff member sat alongside the person during the conversation.

Staff gave us examples of how they respected people's dignity by making sure they were covered during personal care activities. One staff member told us that "privacy and dignity is so important and we must remember that it is essential to respect this for the people we support." They said they did this by addressing all conversation to the person when supporting them and not chatting with their colleagues. A person told us, "Yes, they do respect my privacy when they're washing me."

Staff understood that people's diversity was important and something that needed to be upheld and valued. Care plans took account of people's diverse needs in terms of their culture, religion and gender to ensure that these needs were respected. We saw arrangements were in place for the local priest or vicar to visit the home on a regular basis. People confirmed this and told us that a representative from the church visited the home. A person told us, "My vicar drops in fortnightly."

People and relatives told us that they were involved in making decisions about the care they and their relatives received and that staff always supported them in the way in which they wanted to be supported.

We spoke with a relative during the inspection who told us that their spouse was receiving excellent end of life care. They told us, "It's a place that's somewhere nice. It's wonderful and [person] has a lovely room."

Good

Is the service responsive?

Our findings

People and relatives told us that the staff were responsive to their needs and the needs of their relatives living at the home. A person told us, "On the whole, they're very good." A relative told us, "Some of the individual staff are really good."

We spoke with a visiting professional who told us that staff made prompt referrals, followed through on recommendations and demonstrated a depth of knowledge about the person when the referral was made. They also told us staff were always willing to learn techniques for how best to position a person. We saw a recent review by a palliative care nurse who recommended that the resident was referred to a Speech and Language Therapist. We subsequently saw that this referral had been made. We saw a letter on file from a hospital doctor which commended the home's prompt action of taking the person to hospital to address a potentially serious health situation.

We observed a handover between night staff and day staff. This was carried out by the night nurse who handed over to the daytime nurse by moving from bedroom to bedroom, which ensured that all those who used the service were seen by the next shift coming on duty. Each person, as part of their care planning document had daily log sheets which were completed by nurses and care staff on duty on a daily basis. Information about the person and how they had been on the day and any significant change was recorded on a daily basis.

The home provided a range of activities that met people's needs and reflected their interests. The registered manager told us the budget was for one full-time activity coordinator. However, some care staff demonstrated an interest in running additional activities. For example, we spoke with a staff member who ran a weekly poetry reading and discussion session. They told us that they supported people to choose poems which were then read aloud and usually prompted a wide-ranging discussion.

We received positive feedback from people and relatives regarding the provision of activities. Comments received from people included, "The music therapy, I really like it. I like the singing and musical exercises. I have one-to-one physio twice a week", "I'm not interested in the activities. I like watching TV in my room. I rarely go to the lounge but I'm sure they would take me if I wanted to" and "The activities are very good and music is my favourite on Thursdays, he's wonderful!" A relative told us, "Some of the activities are very well done like the music and she likes the poetry."

We observed a music therapy session which included eleven residents, each one in possession of an instrument which the therapist encouraged them to play. This was a very inclusive session which engaged all eleven people, regardless of disability or musical ability. We met a person in this session who had been in respite care in the home. They told us they had been invited back for lunch and to attend the music therapy session and the poetry session each week.

Pre-admission assessment documents were available on file for people whose care plans were looked at. Prior to admission each person was individually assessed by a member of the management team.

Care plans were personalised and person centred to people's needs and preferences. Care plans were seen to be comprehensive, needs were clearly stated and were focused on the individual. Information provided included communication, behaviour that challenges, maintaining a safe environment, medical conditions, administration of medicines and pressure area care. Care plans were reviewed on a regular basis and updated as changes occurred to people's care needs.

We checked how the service handled complaints. We saw that any complaints received had been investigated fully and appropriately responded to. Most people and relatives we spoke with told us that they had no complaints and were confident that any concerns would be addressed. A relative told us, "I have nothing to complain about. Yes, they do listen."

A compliments folder had been set up by the home which held details of all compliments that were received. Compliments received included, "Thank you to the nurses and staff of the Highgate for all your dedication and care", "Thank you to each and every one of you who helped with giving our mother a dignified last couple of weeks" and "Thank you for looking after me for my two weeks respite care. I am glad to report that I felt safe. The staff particularly the nurse in charge were all cheerful and efficient."

Requires Improvement

Is the service well-led?

Our findings

Overall, people and relatives were positive about the service they received and told us they thought the service was well managed. A person told us, "[Registered manager] very friendly and thoughtful to me." A second person told us, "[Registered manager] is very good. She pops in everyday to say hello." Comments from relatives included, "[Registered manager] is extremely nice and very amenable. We were bowled over at Christmas. It's clean here and never smells", "Yes I would give [registered manager] 100 out of 100. It's got charm here; I come every day and there's warmth and I'd recommend to anyone like a shot" and "I think the manager does her best."

Staff told us that the management was open to receiving feedback and always available to support. Staff also stated that they were very happy with their job and the interaction with the management was very good. Comments from staff included, "We get loads of support. We are really backed up here. I can go to the office", "I get good support from the manager; she listens and makes suggestions which helps me to develop in my work" and "The manager has boosted my self-confidence by making me believe I can do more things." The registered manager told us, "I love this home, I love the residents, and I love the staff."

Visiting care professionals also spoke positively about the registered manager and the management within the home. A visiting health professional told us, "[Registered manager] and [deputy manager] are devoted to the residents." We saw that a monthly meeting took place between the home and the local multi-disciplinary team which included consultants from the local hospital, mental health team, GP practice and pharmacy. People new to the service were discussed and appropriate referrals were made to SALT, Dieticians and Occupational Therapists.

Staff told us that morale within the home was good and that the team worked well together. They also told us that the registered manager and management overall were approachable and they could discuss problems and care issues with them. There was a clear management structure in place and the registered manager and care staff were aware of their roles and responsibilities.

We found that there was clear communication between the staff team and the managers of the home. The registered and deputy manager completed a regular walk around the home. There were regular weekly clinical risk meetings. Staff meetings took place on a quarterly basis for both day and night staff. Topics discussed at recent staff meetings included; focused/themed lunches, staff rewards systems, recent accidents and incidents and staffing levels.

Residents and relatives meetings took place on a regular basis. A person told us, "I think we've had two meetings mostly to do with meals and the food and yes, things did change." There were systems in place to ensure that the service sought people's, relatives and staff views about the
care provided at the home. A relative told us, "I think we got a survey by post." The results of the latest survey were published on the home's website.

There were systems in place to monitor the safety and quality of the service provided. Audits completed

covered areas such as medicines management, care plans, infection prevention and control, health and safety, mystery shopper, monitoring of call bell response times, unannounced night spot checks and quarterly audits of the service by the registered manager. The registered manager also carried out a first impressions audit which involved assessing the outside the home, foyer/reception area, people using the service, home environment, kitchen and dining experience and bedrooms/bathrooms. Findings from quality assurance measures in place fed into a home improvement plan which was updated on a monthly basis. Recent areas identified for improvement included the robustness of risk assessments, monitoring of DoLS applications and outcomes and the robustness of medicines audits. We saw that steps had been taken to address areas identified for improvement.

However, despite the comprehensive systems in place to ensure people received quality and safe care, the quality assurance measures in place did not identify the concerns with medicines management which were raised during the inspection. Following the inspection, the provider submitted additional evidence in the form of supervision notes with registered nurses employed at home. It was noted that concerns regarding nursing practice in medicines management had been identified as far back as February 2017. However actions in place were not sufficient to address the medicines management concerns which placed people at risk of harm as medicines were not always administered as prescribed.

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) The service provider was not providing care in a safe way as they were not doing all that was reasonably practicable to ensure the safe management of medicines.