The Orders Of St. John Care Trust

OSJCT Bohanam House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced inspection took place on 30, 31 March and 1 April 2016.

Bohanam House provides nursing, residential, and respite care for up to 40 people. At the time of our inspection 34 people were living there. There was 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. There were no legal breaches of legal requirements at the last inspection in September 2014.

People received care from staff who generally had the skills, knowledge and understanding needed to carry out their roles. Training for some staff required updating and this had been planned. A new process was completed during the inspection to provide a complete record of all staff training.

People were kept safe by staff trained to recognise signs of potential abuse and they knew what to do to safeguard people. People and relatives told us the home was safe and the service provided was safe. The recruitment procedures followed ensured people were cared for by staff that had appropriate checks completed before they started work and their practice was monitored.

People were supported to make their own choices and decisions where possible. Where people lacked the capacity to make decisions the registered manager had followed procedures for a mental capacity assessment and completed a best interest decision record.

People had access to health and social care professionals and their changing needs were monitored. People's dietary needs and preferences were recorded and they were referred to a dietitian and speech and language therapist if staff had concerns about their nutritional wellbeing. There was a choice of food and people's preferences and cultural differences were respected. The food looked nutritious and people told us they loved the food.

People were treated with kindness and compassion. We observed all staff including housekeeping, catering and care staff spending time with people engaged in conversations or taking part in activities. People told us, "I like it here", "Exceptional carers" and "I like it here, I love the dog". People were encouraged to stroke the registered manager's dog and they considered the dog to be the homes pet. People's bedrooms were personalised and decorated to their taste and they had been involved in choosing decorations for the communal areas.

Care plans were personalised and each record contained information about the person's needs their likes, dislikes and people important to them. The service was supportive and caring to relatives and friends of people nearing the end of their life. The Dignity Champion member of staff monitored practice and supported new staff, leading by example, to ensure that all training given on end of life care and dignity was

practised.

There was a range of activities people could be involved in and regular outings into the community which included the local church, coffee mornings, local markets and walks in the local park. Staff encouraged people to maintain relationships that mattered to them.

The service had quality assurance procedures which included seeking feedback from people and their relatives. Action was taken when improvements were identified. Staff meetings were held and staff were able to influence any changes. Systems were regularly audited to improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

This service was safe.

People's medicines were managed safely to ensure people were receiving appropriate medicines.

People's care and support needs were regularly assessed to monitor the staffing levels required.

People were safeguarded as staff were trained to recognise abuse and to report any abuse to the local safeguarding team.

People were protected by thorough recruitment practices.

The home was well maintained and health and safety and fire risk assessments had been completed.

Is the service effective?

Good

This service was not consistently effective.

Staff training was not always up to date. Individual and group supervision meetings were completed regularly to monitor staff progress and plan training.

People made decisions and choices about their care. Staff were confident when supporting people unable to make choices themselves, to make decisions in their best interests in line with the Mental Capacity Act 2005.

People had access to social and healthcare professionals and their health and welfare was monitored.

People's dietary requirements and food preferences were met for their well-being.

Is the service caring?

Good

The service was caring.

People were treated with compassion, dignity and respect.

Staff treated people as individuals and positively engaged with them.

People were provided with information about community services.

Is the service responsive?

Good

The service was responsive.

People received the care and support they needed and were involved in decisions about their care when possible.

Staff knew people well and how they liked to be cared for.

People took part in many activities and staff engaged with them individually.

Comments or concerns were responded to and changes were made.

Is the service well-led?

Good

The service was well led.

The quality checks completed included people and their relatives view of the service.

The manager was accessible to staff and people and they knew what the visions of the service were.

Regular resident and staff meetings enabled everyone to have their say about how the home was run.

OSJCT Bohanam 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 service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30, 31 March and 1 April 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We received a Provider Information Return (PIR). 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. We used this information to assess how the service was performing and to ensure we addressed any potential areas of concern.

We spoke with six people, two relatives/friends, the registered manager, the quality manager, a nurse, one care leader and one care staff member. We also spoke with the chef, kitchen assistant, activity coordinator, laundry assistant, administration staff, a visiting healthcare professional and a pharmacist who supplied the home with medicines. We looked at seven care records, three recruitment records and maintenance records. We had a copy of the staff duty rosters, quality assurance information and an overview record of all staff training.

Good

Is the service safe?

Our findings

People felt safe living at the home they told us they could have a key to their room if they wished. We spoke with one person who did not wish to have a key and their room stayed open for them. We observed staff knocked before entering people's bedrooms. One person had their blood glucose checked before medicine was given and this was recorded correctly and the protocol was followed. Medicines given 'as required' had a protocol for staff to follow to ensure all staff made the correct decision of when to give the medicine. Homely remedies were agreed by the GP and staff recorded when people had them and why. We observed two members of staff completing medicine administration correctly.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff knew about the different types of abuse and what action to take if abuse was suspected or witnessed. Staff told us they would report any concerns to the home manager who was always available and supportive. The majority of staff were up to date with safeguarding training and the registered manager knew which staff required an update and had planned their training. Staff had a safeguarding procedure to follow and contact details for the Gloucestershire safeguarding team?

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Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. There was a falls monitoring protocol which showed monthly accidents and how they could be reduced. After a fall peoples care plans were updated and staff held a meeting to discuss preventative measures.

Safe recruitment practices were followed before new staff were employed. Checks were made to ensure staff were suitable and of good character. We checked recruitment records and suitable checks had been made to ensure people were safeguarded. Nurse registrations with the Nursing and Midwifery Council were checked. Potential new staff were introduced to people in the home to see how they engaged with them. Volunteers had the same checks to ensure peoples safety. The registered manager told us they had recruited a new nurse recently and had no current vacancies.
Staff had a six month probationary period when they started. The registered manager completed three reviews of their conduct during the six months to monitor staff progress. Currently12 staff were completing a probationary period.

When staff had left the service an exit interview was completed by the registered manager to determine the reason. This was done to improve recruitment practices and retain staff, providing consistency of staff for people.

There were safe medicine administration systems in place and people received their medicines when required. We spoke with the head nurse who showed us the medicines were securely stored. Staff medicine administration training was up to date. The medicine administration records we checked were correct. One person had their blood glucose checked before medicine was given and this was recorded correctly and the protocol was followed. Medicines given 'as required' had a protocol for staff to follow to ensure all staff made the correct decision of when to give the medicine. Homely remedies were agreed by the GP and staff

recorded when people had them and why. We observed two members of staff completing medicine administration correctly.

There had been six minor medicine errors in the previous six months and these were reported to the registered manager and provider. Staff had met to discuss prevention of errors and we looked at meeting records where staff had identified shortfalls in practice, These were mainly signature omissions where staff had not signed for the medicine they had administered. We were informed about a proposed new electronic medicine system which will eliminate some errors. Staff explained there was sufficient time to administer medicines and one person we spoke with told us they always had their medicines on time.

Medicine administration competency checks for staff were completed every two years. This was about to change to every three years. We discussed the safety of the new arrangement with the registered manager and they assured us staff that required a competency check would complete one.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. There was a dependency tool used for each person, which was updated six monthly. The registered manager told us the new system for calculating staffing levels was realistic. Currently the service had more staff than the calculations identified for the 34 people accommodated and their dependency needs. The service had five care staff on the internal 'bank' system that could fill in for absent staff. The registered manager told us agency nurses had recently been used for night time. We looked at the records available for calculating staff numbers which supported what the manager told us. Staff told us they felt well supported and there was enough time to do their job. They said, "Occasionally things may get busy but the management team would help if needed".

Individual risks were identified and minimised to maintain people's freedom and independence. The care plans had clear risk assessments for people for example; falls, moving and handling, and for bed rails. The risks were reviewed monthly and any changes were noted and action taken to minimise risks and deterioration in health and wellbeing.

The home was well maintained and health and safety and fire risk assessments had been completed. The registered manager was qualified to complete health and safety risk assessments and held quarterly meetings with maintenance staff to monitor any risks.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. There was a detailed contingency plan which covered emergencies for example, power failure and loss of information technology and adverse weather conditions.

There were infection control procedures for staff to follow and they completed training every two years to ensure they were updated with the latest guidance to prevent cross infection. We observed staff using personal protective equipment, for example plastic aprons and gloves, to promote infection control. The laundry was clean and well organised to help ensure infection control procedures were met.

Good

Is the service effective?

Our findings

People received care from staff who generally had the skills, knowledge and understanding needed to carry out their roles. Of the 60 care staff a total of 18 staff had completed the National Vocational Qualification (NVQ) in health and social care and one staff member had a NVQ management qualification. Staff had access to a range of training to develop their skills. All staff completed induction training before they were able to support people. This included safeguarding, moving and handling and infection control training. A total of 15 staff were currently completing their induction programme.

Training for some staff required updating and this had been planned. For example ten staff required an update to their safeguarding training and nine for infection control training. The registered manager had a handwritten file where they recorded individual role specific training staff had completed to identify when they required an update. The manager told us it had taken time to check all sixty staff when planning training. The new training overview, completed during the inspection, ensured the registered manager and the staff had a complete and accessible record on the wall of when all training was due.

The Care Certificate had just been introduced and would be completed by all new staff members. The care certificate lays down a framework of training and support which staff can receive. The aim is for new care staff to be able to deliver safe and effective care to a recognised standard once completed. There was a Care Certificate lead member of staff to ensure staff were well supported.

Staff told us they had the training and skills they needed to meet people's needs. Staff confirmed they received training on a range of subjects. One nurse told us they had just updated their knowledge and skills which enabled them to continue to assess wounds and use the correct dressings. A total of 53 staff had completed End of Life care training.

People were supported to make their own choices and decisions where possible. Daily records informed us one person living with dementia had given their consent for a full body wash most days. Where people lacked the capacity to make decisions the registered manager had followed procedures for a mental capacity assessment and completed a best interest decision record. Staff understood the principles of the Mental Capacity Act 2005 (MCA). The 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. Examples seen were best interest records for people unable to sign consent for the completion of identification information, for example photographs and for the addition of bed rails.

Staff had regular individual meetings with senior staff to support them, monitor their work and identify any training needs. The registered manager had planned three individual meetings annually for all staff. Face to face training was organised for the staff to support computer based learning. Records of individual staff meeting told us staff had training objectives planned, for example, dementia care and care planning training. New staff told us they had completed individual meetings while on probation.

The service was working within the principles of the MCA and conditions on authorisations to deprive a person of their liberty were being met. The registered manager had identified a number of people who they believed were being deprived of their liberty. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had made 14 DoLS applications to the supervisory body, one had been authorised. There were clear mental capacity assessments, best interest records and detailed care plans for the DoLS applications made and authorised.

People's dietary needs and preferences were recorded. People were referred to a dietician and speech and language therapist if staff had concerns about their nutritional wellbeing. People's specific dietary requirements were recorded and any additional information from health professionals. One person had a percutaneous endoscopic gastrostomy (PEG) where liquid food was given directly to them by tube. There was a record of all the liquid food and any other food given to them which the catering staff were also aware of.

We spoke with the chef and an assistant who were aware of people's nutritional needs. Information about people's dietary risk from malnutrition and choking was recorded in the kitchen. This meant that some people required a special diet. Both staff told us they enjoyed their roles and said the atmosphere was happy and friendly in the dining room where the majority of people had their meals.

People had a choice of food and staff showed them visually on a small plate so they could choose. Additional options were available every day. We saw one person chose an omelette which was freshly cooked for them. The food looked nutritious and people told us they loved the food. Drinks were served in appropriate cups and people had several choices. One person had specific likes included in their dietary care plan which met their cultural preferences.

We observed staff during lunchtime and they were positively engaged with people. Staff spoke to people calmly and encouraged them to socially engage with others. People could choose to eat in their room or in the dining area. Staff assisted people to eat and people were relaxed and happy. The kitchen was clean and spacious. People could talk with the chef as the kitchen was open with a serving counter.

People's changing needs were monitored to make sure their health needs were responded to promptly. Records confirmed people had access to healthcare professionals for example, a GP, a diabetic specialist team and a tissue viability nurse.

Good

Is the service caring?

Our findings

Staff knew people well and were concerned for their wellbeing and responded to them in a caring way. People's privacy and dignity was respected by staff that always knocked on bedroom doors and waited for an answer before they entered. People and their relatives told us they liked the staff that supported them. Relatives told us, "It's fine here, I feel able to approach the management with issues" and "It's wonderful here". People told us, "I like it here", "Exceptional carers" and "I like it here, I love the dog". People were encouraged to pat the registered manager's dog and they considered the dog to be the homes pet. A relative commented at a residents meeting that her mum was very happy and the staff were always very kind to her.

People were treated with kindness and compassion. We observed all staff including housekeeping, catering and care staff spending time with people, engaged in conversations or taking part in activities. There was a sense of fun which the staff promoted. Staff described people in a positive manner. One member of staff told us, "I have two people who I am their keyworker and I organise a treat for their birthday and help them with their life stories and check they have enough toiletries" A keyworker is a member of staff that makes sure people have everything they need with regard to personal care, their care records are updated and all outings or activities are prepared for when required. We observed staff were unrushed and caring in their attitude towards people.

People had a separate file in their care plan called "All about me". This gave an insight into people's lives and included what they liked to be called, their interests, information about their working years, how to communicate with them, what mattered to them and their likes and dislikes. There were photographs of people in their younger years to look at. Staff could start meaningful conversations with people after reading these and we observed this. One "All about me" was blank and it was explained to us that the person did not wish to complete this or for their family to add information.

People's bedrooms were personalised and decorated to their taste and they had been involved in choosing decorations for the communal areas. There was signage in the home that helped people find their way and recognise bathrooms and toilets were located. An old dresser with vintage crockery and a reminiscence room decorated like a 'front room' was valued by people. A kitchen area on the second floor was provided with comfortable seating for people and their families to meet and make a hot drink together.

Staff knew, understood and responded to each person's diverse cultural, gender and spiritual needs in a caring and compassionate way. A care plan for a person who did not speak any English had advice from relatives on how care support could be provided. Visual aids were used with pictures for the person to point to when communicating. Staff were encouraged to use basic greetings in the person's own language, for example, "Good morning", "Thank You" and "How are you". These were included in the care plan. An interpreter's telephone number was available if staff required support. A local support group from the person's own cultural community made regular visits.

There were several information boards that included information about advocacy services and

safeguarding. The registered manager told us people were not currently using an advocacy service. A dignity board told people which member of staff was the Dignity Champion. It gave advice on how people should be treated with dignity and respect. A Dementia information board included The National Institute for Health and Care Excellence (NICE) quality standards for dementia. It also included The Orders of St. John Care Trust Dementia Care Good Practice guide. There were many leaflets for people and their relatives to take away.

People and their relatives were given support when making decisions about their preferences for end of life care. Where needed, people and staff were supported by palliative care specialists. Peoples advanced decisions were respected. A care plan we looked had recorded a person's end of life wishes which included remaining in Bohanam House rather than being admitted to hospital. The information was evaluated monthly. When people had a relative with an implemented Lasting Power of Attorney this was recorded and they were included in reviews about people's care.

The service was supportive and caring to relatives and friends of people nearing the end of their life. This was apparent by the provision of an 'End of Life Care' box containing a range of toiletries offered to them when they may not want to leave their loved one. Relatives and friends were also encouraged to join in with meal times and events in the home to promote a family friendly home. The Dignity Champion monitored practice and supported new staff, leading by example, to ensure that all training given on end of life care and dignity was practised. This helped to ensure that each person was treated individually with dignity and respect, were pain free and comfortable in familiar surroundings. The registered manager told us the GP's were, "Amazing" when they supported people with their end of life care.

The complimentary letters we looked at from relatives had the following comments about the staff, "Many thanks for the lovely lunch you provided for my mums niece and her son, it was very kind of you all and the presentation of the table was first class. You all do such a good job every day. Bless you all", "Our special thanks to all the staff at Bohanam house for the loving care my relative received over four and a half years with outstanding end of life care, which could not have been any better" and "Many thanks to X, Y and all of the staff and residents who helped to make my relatives 100th birthday wonderful. A big "Thank You" from all the family. It was fantastic".

Good

Is the service responsive?

Our findings

Care plans were personalised and each record contained information about the person's needs their likes, dislikes and information about the people who were important to them. The care plans were detailed and included information to enable staff to get to know the person. There were also care plans for short term specific needs for example, wound care. The wound care records had detailed information and photographs to help monitor progress. People had regular six monthly reviews where they told staff what they liked and disliked about the service. One person said "The three things I like most are, feeling liked by staff, caring staff and well laundered clothes".

There was a 'resident of the day' identified and staff reviewed their care plan and ensured they were complete and had been reviewed as part of the quality assurance procedures. We observed the 'resident of the day' care plan was being reviewed with the person. Daily records explained how people were feeling, their food and drink intake, activities completed and any specific acute care needs for example, medicine for pain relief. A visiting healthcare professional told us wound care was well recorded and people were referred to them quickly. This demonstrated clear and professional practice to enhance peoples care and wellbeing.

A person observed by staff to see if any particular triggers made them anxious had a detailed record completed. This gave the mental health professionals valuable information when considering their care and treatment. There was clear information in the care plan how a person living with dementia became anxious in the late afternoon period. The doll therapy used, which is considered to be beneficial for people living with dementia in a period of uncertainty reducing their anxiety when holding a doll, had improved their mental health and wellbeing.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. There was detailed information about each person on the handover records which were updated weekly or as necessary. We observed a handover where valuable information was shared and people's progress was communicated between the staff to help provide consistent care. For example staff handed over that a relative was involved in completing information for 'resident of the day' care plan review and a person living with dementia had been anxious the day before. Staff were advised to carefully explain everything to them to reassure them. A liquid food tube wound required attention and later we checked the wound care had been completed. Staff signed peoples fire evacuation record was correct at each handover session which ensured they would receive the help they needed. A communication book was also used to inform staff about any changes, for example when people no longer required repositioning to prevent skin deterioration.

The service had good links with the local community. Staff actively encouraged people to maintain relationships that mattered to them. One relative told us improvements had been made and their relative was supported to visit a relative in another service and that was important to them. The activity co-ordinator told us people had regular outings into the community and this included the local church, coffee mornings, local markets and walks in the local park. The care plans recorded clear lines of communication

with family and other professionals. One person we spoke with said they wished they could access the community more, and that more space in the minibus for wheelchairs would be an improvement to their social well-being. This was discussed with the manager who stated this would be addressed.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. We observed staff organising activities including a sit down exercise session using a DVD and an arts and crafts session. People told us the activities on offer were varied and good fun. Some examples of these were weekly quizzes, bingo, skittles and sewing or knitting. People who had sight impairment were encouraged to take part and one person had started knitting with support from others. A member of staff told us the activities for people were excellent and staff joined in with them to support them.

There was a complaints policy and procedure in place. People and their relatives knew how to make a complaint if needed and concerns had been responded to. A suggestion box was available but had not been used. There had been no complaints in the previous two years. Complaints and concerns were taken seriously and used as an opportunity to improve the service. The last complaint investigated was recorded in detail for the local authority. Concerns from families were recorded in the persons care plan and highlighted as dealt with. Concerns raised by people at residents' meetings were recorded and addressed. For example people wanted an additional cup of tea with their dessert at lunchtime and their bed made more promptly each day.

Good

Is the service well-led?

Our findings

The registered manager valued the feedback from people and staff and acted on their suggestions. Staff told us they were consulted and felt valued. There was a plan of all meetings held with different staff and relatives/residents. Staff spoke positively about the team and leadership in the home. The registered manager was described as approachable and available for support. One staff member told us the registered manager was, "Firm but fair". A staff meeting held on 3 March 2016 had recorded training staff had requested. The syringe driver training requested had been completed.

People and those important to them had opportunities to feedback their views about the home and the quality of service they received. One person told us they attended the residents meetings. They explained they were able to influence the activity programme and save money for the resident's amenity fund. The registered manager agreed an exercise programme would be provided internally to people's satisfaction. Relatives told us they were happy with the registered manager and if they had any issues they could tell her about these.

Quality assurance systems were in place to monitor the quality of the service delivered and the running of the home. Six monthly reviews with people recorded their comments about the service but had not been gathered to show the overall actions taken. We noted a person wanted the television lowered in their six monthly reviews and this was achieved.

The Carehomes website comments were used as part of the services quality assurance. Comments were on the website from people or their relatives. The service had been rated 8.7 out of 10 from 11 comments in the last two years. We looked at five comments made in the last six months. The registered manager monitored the information and replied when concerns were raised on the website. People commented, "This is my first experience of being in a care home and I have found this to be absolutely first class. I have found the staff excellent and I would not hesitate in coming back again in the future", "Whenever a problem arises, my family can contact the home manager or her deputy who will always find a way to solve the problem", "Bohanam House always welcomes my family members when they visit which is very often. Nothing is too much trouble".

Relatives commented, "Whenever we visit Bohanam we are always met with a friendly smile and warm welcomes from all the staff. The residents are very well cared for and I am delighted with the dedicated care my auntie has always received", and "Good at organising birthday parties and practical arrangements for external medical (hospital) appointments".

Concerns were raised on the website about the delay in answering call bells which the registered manager replied to and informed the person about regular call bell monitoring printouts. Any lengthy delays in answering call bells were raised with the care team. The registered manager monitored the call bells weekly and looked at trends monthly. Night call bells were answered within a minute and when a call bell was unanswered for more than 10 minutes this was investigated and discussed at the next staff meeting. The registered manager was considering changing deployment of staff as call bell monitoring indicated a

problem during staff break times.

Staff leaving was a concern raised and the registered manager informed the person some very experienced and skilled care staff had been recruited and there were no concerns over current staffing levels. The registered manager invited relatives to discuss anything with her when they next visited.

Staff 'champions' were involved in meetings to assess the quality of the service. The services aim was to have confident and skilled staff. There were 'Champion' staff members for different areas of care practice for example, dignity, dementia care, infection prevention and control, medicines, falls management and tissue viability. The registered manager told us the 'champions' expertise will be built upon to enable staff to use their knowledge for advice and guidance.

Audits had identified some shortfalls and action had been taken to address these. The provider's own Care Quality Compliance Tool assessed the service's quality in 2014 - 2015 as 97.2% compliant and all required actions were completed. For example, a reflective meeting about the prevention and care of pressure ulcers was completed. The next external audit was due in March 2016. The area manager and the registered manager completed monthly checks and quarterly audits. There was evidence of learning from accidents and incidents and appropriate changes were made. Incident reports were produced by staff and reviewed by the registered manager.

Peoples care plans audited in the last two months totalled 20 of the 34 people accommodated and all care plans were being gradually replaced with the new care planning system. The action plan for the last quarterly audit identified risk assessments and laundry cleaning was incomplete and this had been completed. Recent fire and health and safety checks were complete. Fire training was completed and a fire drill in February 2016 involved 17 staff which indicated fire training was put into practice.

Medicine procedures were audited quarterly. The local pharmacist completed a six monthly audit during the inspection and identified the ordering process was clear and concise. The result of the audit was good and the pharmacist had not required any actions to be completed.

There was an improvement plan for the environment where 16 bedrooms had been upgraded and there were eight additional ones to be completed. A wet room bathroom, internal decoration, electrical work and external repairs to the building were examples of planned improvements.