Rowley Care Ltd

Rowley House Nursing Home

Inspection report

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14 December 2018

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 13 and 14 December 2018. This was the first time the home had been inspected under this provider. At this inspection we found some breaches of regulations. You can see what action we asked the provider to take at the back of the full version of this report.

Rowley House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Rowley House Nursing Home can accommodate up to 35 people, based in one building. There were 24 people using the service at the time of our inspection, with one other person also living there who was in hospital.

There was no registered manager in post, although there was a manager who was in the process of applying to register with us. 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.

Quality assurance systems in place to monitor the service were not always effective at identifying concerns and prompt action was not always taken to ensure people's care improved. Feedback sought from people and relatives was not always acted upon promptly. Feedback from other professionals was also not always acted upon quickly enough, so concerns identified continued to be an issue.

Medicines were not always managed safely and we could not be sure people were always getting them as prescribed. Risks were not always assessed and reviewed sufficiently to ensure lessons were learned. However, people felt safe and staff understood their safeguarding responsibilities. Staff were safely recruited to help keep people safe.

There was mixed feedback about staffing levels and the skills mix of staff had not always been considered. People were protected from possible infection by measures in place and the building was appropriately maintained.

People were not always supported to have maximum choice and control of their lives as the principles of the Mental Capacity Act 2005 were not always being followed, although staff did offer choices. Decisions made in people's best interest were not always recorded. We could not be sure that all necessary Deprivation of Liberty Safeguarding (DoLS) referrals had been made as capacity assessments were not always undertaken or reviewed.

People did not always find the choice of food sufficient and felt the food needed improving. Staff received training and were supported in their role to care for people. People had access to other health professionals to help keep them well. The building was suitably adapted for the people living there and improvements to

the décor were ongoing.

People found that staff were kind and caring and they were encouraged to be independent and to be involved in decisions about their care and support. People could personalise their bedrooms and there were no restrictions on visiting times for relatives.

People were not always sufficiently supported to partake in enough activities as staff were not always available. People and relatives felt that staff knew their preferences well, although further consideration of people's protected characteristics would be beneficial. People felt able to complain and thought their feedback would be dealt with. Consideration had been given to people nearing the end of their life and arrangements made to ensure medicines were available so they would be pain-free.

People, relatives and staff were positive about the manager and felt the manager was approachable. Staff felt supported.

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.

Medicines were not always managed safely.

Sufficient action was not always taken when risks to people had been identified.

There was mixed feedback about staffing levels but staff were recruited safely.

People felt safe and were protected from potential abuse.

People were protected from the risk of infection and the building was being appropriately maintained.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Records did not reflect that the principles of the MCA 2005 were being followed to ensure that decisions were always made in people's best interest.

People did not always feel there was enough choice of meals.

People had access to healthcare professionals.

Staff received training and felt supported in their roles to be able to care for people effectively.

The home was suitably adapted for people using the service and improvements to the décor were ongoing.

Is the service caring?

Good

The service was caring.

People were treated with respect and told us staff were kind.

People were supported to be independent and make choices about their care.

People could personalise their bedrooms and there were no restrictions on visiting times.

Is the service responsive?	**Requires Improvement**
The service was not always responsive. People were not always supported to partake in enough activities. People were supported in the way they preferred although some care plans lacked detail. Consideration was given to planning for the end of people's life and to ensure they would be pain-free. People and relatives felt able to complain.	
Is the service well-led?	**Requires Improvement**
The service was not consistently well led. Quality assurance systems in place did not always identify areas for improvement and timely action to remedy concerns was not always taken. People and relatives were asked for their opinion about their care but this was not always acted upon. People, relatives and staff felt positively about the registered manager.	

Rowley House Nursing 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 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.

The inspection took place on 13 and 14 December 2018 and was unannounced. The inspection was carried out by one inspector and a medicines inspector.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident may be subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of medicines. This inspection examined those risks.

We looked at information we held about the service including statutory notifications submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also asked Healthwatch and local commissioners if they had any information they wanted to share with us about the service. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care services. We used this information to help plan our inspection.

We spoke with one person who used the service and four relatives. We also spoke with four care staff, two nurses and two other health and social care professionals. In addition to this we spoke with the provider, manager, deputy manager, the maintenance person and an activity coordinator. We made observations in communal areas. We reviewed the care plans for four people who used the service, as well as medicine records for eight people. We looked at management records such as quality audits and the ways in which the provider monitored the home. We also looked at recruitment files for two members of staff.

Requires Improvement

Is the service safe?

Our findings

People did not always have their medicines well-managed and did not always receive them using best practice principles. The administration records for tablets demonstrated that people were getting these medicines at the times they needed them. However, the administration records for liquid medicines did not always demonstrate that they were being administered in accordance with the prescriber's instructions.

Nurses left the medicines trolley in one place, then walked to the area the person was to give them their medicines. The practice of walking around the home with prepared medicines increased the risk of them being administered to the wrong person or being spilt over the floor.

Records relating to the application of pain-relief patches were not robust enough to demonstrate where the patches were being applied to the body. Consequently, the provider was not able to demonstrate that the patches were being rotated around different sites of the body in line with the manufacturer's guidance. This meant there was a risk the patches were not being applied safely and could result in people experiencing unnecessary side effects.

People who had been prescribed medicines on a 'when required' basis did not always have enough information recorded to inform staff of how and when to administer these medicines. The lack of detail to describe symptoms meant that there was a risk that people might not get the most appropriate treatment when they needed it.

Where people needed to have medicines administered directly into their stomach through a tube the provider had not ensured the necessary information was in place to ensure these medicines were administered safely. Nursing staff confirmed they had administered medicines through a tube that morning and had not seen any information on how to prepare and administer the prescribed medicines. Discussions with and an observation of the nursing staff found the methods they used did not match best practice of administration and placed people's safety at risk.

Some people were self-administering some of their prescribed medicines. We found that the provider had not carried out a risk assessment for all those self-administering their medicines. One risk assessment failed to identify what risks the act of self-administration posed to the individual and other people living within the service. There was no evidence that the service was monitoring these people to ensure they were taking their medicines correctly and safely. This meant the provider was unable to demonstrate that people were self-administering their medicine safely and as prescribed.

We found that the refrigerator temperatures were not being correctly measured. We asked a member of staff to show us how the nursing staff were measuring the maximum and minimum temperatures. We found the measurements being recorded were not the maximum and minimum temperatures of the refrigerator. The provider therefore could not show that medicines being stored in the refrigerator would be effective in treating the conditions they had been prescribed for.

Risks to people were not always assessed, planned for and managed appropriately. For example, one person had experienced multiple falls. The person was supposed to be checked periodically by staff to ensure they were safe. One staff member said, "I don't think enough is being done to stop [Person's name] falling. If we're giving someone personal care with two of us, how can we be down there keeping an eye on [Person's name]" and they went on to say, "How can we keep running back and forth [to check on the person] and look after everyone else?" The person's care plan or risk assessment was not reviewed following each fall. The person did have some equipment to try to reduce the likelihood of falls, however this proved unsuitable. Other options, such as different equipment, more frequent checks or more supervision by staff had not been considered. This meant lessons had not always been learned and action not always taken to reduce the likelihood of a reoccurrence.

These issues constituted a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was mixed feedback about staffing levels. One relative said, "There's not enough staff, no." Whereas another relative told us, "I would say there is enough staff; if the buzzer has gone, someone has been there quickly." One staff member said, "It's not too bad at the moment as we're not full, but there isn't usually enough staff. Mornings are the worst time, we struggle to get everyone up. This morning there are not many [people] up [out of bed]." We observed most people were not out of bed for a lot of the morning, however people did not have to wait for support if they needed it. Another relative told us, "[My relative] doesn't have to wait too long for support but they could always do with more staff." Another staff member said when asked about whether there were enough staff, "Yes and no. Skills mix is a big thing in this place. We have good carers and not so good ones. There are some slower carers." Another staff member also commented about the skills mix, "It's the skill mix; there are days when the shift is hard as some [staff] don't have good time management or don't pull their weight." A staff member gave us an example, "Today has been a bit tough as they had a new carer last night. Not many people were up, so we're playing catch up until 8 o'clock tonight." A relative confirmed this, "My relative is still in bed. They were yesterday morning too, but they aren't often up before I get here." We also observed that very few people were out of bed. The manager and deputy manager used a dependency tool to help determine the staffing numbers, however this did not consider the skills mix of staff. This meant further consideration was required of how staff worked together and staff skills mix to ensure there were sufficient, suitably deployed staff.

People told us they felt safe and they were protected from the risk of potential abuse. One relative said, "I feel [my relative] is really safe as I can ask the staff anything." All other relatives also felt their relative was safe. People were protected from potential abuse. Staff were able to tell us about the different types of abuse, the signs to look out for and what action they would take if they were concerned for people. We also saw that referrals had been made to the local safeguarding authority. We observed people being supported to move safely. Staff offered encouragement and explained the process to people. If people were being moved in a wheelchair, they were helped safely as their feet were on footplates to avoid injury. When people were hoisted this was done with two staff to keep people safe and people seemed relaxed and comfortable when being hoisted.

We saw that before staff started work they had checks to ensure they were of a suitable character to care for people who used the service. Pre-employment checks were carried out such as getting at least two references and verifying a staff members identity. Checks were also carried out with the Disclosure and Baring Service (DBS). The DBS service checks if someone has a criminal conviction or not. This meant people were being protected by the recruitment systems in place.

People were protected from the risk of infection as systems and processes were in place to ensure the home was clean and tidy. One relative said, "[My relative] always has clean sheets and laundry and the staff wear gloves and aprons" and they went on to say, "The cleaners are very good, I have no concerns about smells." Another relative said, "Staff wear gloves and aprons and the place is spotless."

The building was appropriately maintained to help keep people safe. Checks took place on things such as the gas, electrical equipment and fire detection and equipment. Personal emergency evacuations plans (PEEPs) were also in place in case of the need to evacuate the building, to help staff and emergency services identify how to support people to leave the building.

Requires Improvement

Is the service effective?

Our findings

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. The documentation about people's capacity was not always clear, sometimes conflicting and had not always been reviewed as necessary. For example, one person had a capacity assessment when they moved in in 2017, when the home was being run by a different provider. However, the outcome of the assessment was not recorded as to whether the person did or did not have capacity; although the responses recorded suggested the person did not have capacity. The assessment was also not decision-specific, so it was not known what was being assessed. The same person was also asked to sign consent for a variety of areas such as sharing of their information and for having their photo taken the same week they had been assessed as not having capacity and their ability in these areas had not been specifically considered. The assessment had been reviewed since the new provider had taken over and these concerns had not been identified. Another person had moved in during 2018; a relative had signed consent on the person's behalf but the person's capacity and ability to consent to these areas had not been checked. The relative's legal right to sign consent on the person's behalf had also not been checked. Staff told us the person had changed a lot since they moved in and records suggested the person may need their capacity reviewing; however, this had not happened. Decisions taken in people's best interest were not always fully recorded and it was not always possible to see who was involved in these decisions.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. We saw that some people had been referred for a DoLS authorisation. However, as people did not always have their capacity assessed, or reviewed, when needed, it meant there was a risk that some applications may not have been submitted as it had not been identified that some people may require a DoLS application. Staff helped people to make a decision where possible and offered some choices. One staff member said, "I talk through and have communication with the person. I ask them how they are." This meant that staff were supporting people to make day to day decisions, but further work was required to ensure decisions made in people's best interests were documented and people had their decision-specific capacity assessed.

People, relatives and staff told us they felt the food could be improved; particularly the food for those who needed a soft or pureed diet. One person said, "I don't usually have a choice. If I'm having a bad day [with my health] I look forward to lunch but I don't like it here. It's not that nice." When we asked a relative what could be improved the most in the home they said, "The food could be. It's just basic meals." Another relative said, "[My relative] doesn't think much of the food." One staff member said, "I'm sick of giving people soup and sandwiches, they need more choices" and they went on to say, "Now and again people get a choice, but those who have puree only have one choice." Another staff member said, "It would be nice for the people who need pureed food to have more choice. For tea time it is just soup [for those on a pureed diet]." A recent survey of people and relatives identified some similar feedback, such as food variety was 'repetitive' and that more choice was needed. This meant more consideration needed to be given to the range of food choices available to people to ensure they enjoyed the food they had.

We saw people were supported to access health professionals to help keep them healthy. One relative said, "I can ring about anything. The advanced medical practitioner comes to see my relative. Staff always get someone to [my relative], even in the middle of the night and they always call me." Another relative told us, "Staff get medical attention, right away." A visiting health professional told us, "[Staff will] absolutely follow my guidance to the letter. For example, today I've done an assessment and given them written down advice and reasons and I know it will be followed" and they went on to say, "They [staff] ask for my advice too."

People had an assessment carried out before they came to live in the home to ensure their needs could be met. Consideration was given to the type of plans that needed to be put in place to support people with their conditions, such as diabetes. Records confirmed people had access to a range of other health professionals such as community psychiatric nurses, GPs, occupational therapists and physiotherapists.

Staff had received the training and support that they needed to work effectively in the home. Relatives told us staff were well trained and staff confirmed they received training and felt supported in their role. One relative said, "Staff are well trained, they have training sessions on lifting. The nurse in charge of [my relative] does training for that." A member of staff said, "We get lots of training, I enjoy the training and I like getting a certificate. I've gained my NVQ, I'm so proud of myself, they offer it to us here. We do online and face to face training." Another staff member said, "They [the management] will help if we need help." Training records showed staff received training and we were also told of a new system which was recently introduced to do some online training and keep a record of the training staff had completed.

The home was suitably adapted to cater for people who used the service. However, some areas required decorating and improvements were ongoing. Relatives and staff told us there had been improvements and a new television purchased which was much bigger so people could see it more easily. One relative said, "The environment has improved." One staff member said, "There is a new TV all singing and dancing. The home is getting modernised, I'm happy with what the provider is doing." Another staff member commented, "The lounge is so much more homely, they are trying their best to make it homely." The provider told us, "It [the home] was really dated. We've changed all the windows, put new flooring down and got rid of the wallpaper. People get to personalise their room and choose the furnishings." There had been a pause in the re-decoration of the home during the Christmas period, which was to continue in the new year.

Good

Is the service caring?

Our findings

People were treated with dignity and respect. One relative said, "Staff are the best thing – from the cleaner to the top. I can voice my concerns and they listen and they care, they're going out of their way to make Christmas a joyous time." Another relative said, "I can't fault the care, even down to the cleaners and entertainment. [My relative] is treated with kindness and respect. They've never said a bad word. [My relative] can't talk and they're so kind to them. Staff are all so kind." Other comments included, "Very good with dignity" and, "All staff are very personable, even if not doing a task." The maintenance person also said, "I'm very much as if my mom and dad were here. If I see something that isn't my job, it really is my job as we all have a duty of care." All staff we spoke with were able to tell us how they supported people to maintain their dignity when supporting with personal care, such as keeping curtains and doors closed and keeping them covered where possible.

People were involved in choices about their care and to try and remain as independent as possible. One relative said, "Staff do try to give a choice and demonstrate a couple of options." Another relative said, "[My relative] had given up on life" and went on to say, "Staff help maintain their independence." One staff member said, "I get people to wash themselves and talk to them as it puts them at ease more if you talk to them; it must be so difficult [having personal care]." We observed people being offered choices of where to spend their time and choices such as what drinks to have.

We were told by relatives that they could visit when they chose to and that visitors were made to feel welcome by staff. One relative said, "I can visit whatever time I want. They treat me like a resident!" We saw that people could personalise their bedroom and had many personal effects to decorate their room. People's right to privacy was respected as we saw that people's care plans were stored securely in a locked office so that only those who needed information about people could access it.

Requires Improvement

Is the service responsive?

Our findings

People were not always supported to partake in activities as often as they would like, with weekends particularly lacking engagement. One relative said, "[Staff name] is entertainment, they are absolutely brilliant, they have people making cards, does games, [my relative] partakes. But when [staff member] is not here there's nothing to do. [My relative] stays in their room on Saturday and Sunday as there is nothing to do." Staff told us they felt there wasn't always enough to do and they didn't have time to support people with activities. A member of staff told us, "There isn't enough for people to do, by far. They just sit in their chairs all day. [Activities coordinator] does their best but it's not enough time. We don't have time to do activities." Another staff member told us, "We haven't got time to do activities; we're doing personal care, meal times, so it's never ending. It'd be nice to go around and paint nails and have a chat." Other comments from staff included, "Activities could be better – they don't do anything at weekends, people still come to the lounge but there's nothing to do" and "Monday to Friday [activity coordinator] is here; we had a singer on Monday. It was lovely to see everyone singing and dancing. Weekends there's just the TV. There are board games, but staff don't have time to do them with people." This meant that people were not always supported as often as they would like to be able to access activities and hobbies of their choice as staffing was not always available to support this. We recommend consideration be given to ensuring people have consistent access to hobbies and activities when they choose to.

People told us they had their preferences catered for and were well supported. One relative said, "Staff can understand [my relative] better than I can." Another relative said, "Staff know [relative's name] well and how he likes to be supported" and also said, "Nurses talk to me about my relative's care and support needs. I only have to ask if [my relative] needs anything." Another relative said, "Staff asked about likes and preferences, what my relative likes to do. Staff know [my relative] as an individual, not just as a patient." Another relative also commented, "I think they [staff] know [my relative], they've made a real effort." Some care plans lacked personalised details about people and did not always contain information about how people liked to be supported. However, there was a stable staff team so staff could get to know people.

We asked how people with protected characteristics under the Equalities Act were supported; these characteristics include gender, sexual orientation and religion, for example. We asked the manager about how they ensured they were giving people the opportunity to discuss their protected characteristics and they told us this was on their care plan when they first moved into the home. However, we found not all protected characteristics had been included, such as whether someone identified as lesbian, gay, bisexual or transgender and other characteristics, such as religion, that had been included were not always fully completed. This meant there was a risk that some people may not feel able to discuss some of their support needs. However, despite there being a lack of detail, people and relatives felt the care staff knew them well.

No one was imminently nearing the end of their life at the time of our inspection. However, we saw some basic end of life plans in place for people and medicines were available for a person to ensure they had a pain-free death when the time came. A relative we spoke with about the end of their loved one's life raised no concerns with us. This meant the service was considering people's end of life needs. We will check this again at the next inspection.

People felt able to complain and felt action was taken based on their feedback. One person told us, "When I've complained they've done something about it." One relative said, "Even if it is something that's worrying me, they act on it straight away." Another relative commented, "I've not raised any concerns. The staff are wonderful. I can just ask. There's not a member of staff I can't talk to." Other comments from relatives included, "We've not had reason to complain, other relatives in other care homes have, so here is better" and, "We've not had to raise any concerns, but would feel able to. I think they would take our concerns on board."

Requires Improvement

Is the service well-led?

Our findings

Systems in place were not always effective at identifying concerns and ensuring swift action was taken to resolve them. The local authority had carried out a monitoring visit in July 2018 which identified multiple concerns, including in relation to medicines and the recording of accidents and incidents. The local authority re-visited the service in November 2018 and continued to find some of the same concerns they had previously found. Our inspection also found similar concerns. The pharmacy carried out an audit of the medicines and records in the home and found some areas for improvement – some of which were the same as the local authority findings and the same as our inspection findings. Whilst the provider worked in partnership with other health professionals to support people, they had failed to work in sufficient partnership with other organisations to take effective action to improve the service. This showed the provider had failed to take sufficient action to ensure feedback from professionals was listened to and acted upon.

Some incidents, such as falls or a person being found on the floor, were not being recorded on incident forms so were not all being captured in one central place. There was a variety of ways that staff were recording incidents, for example some were in a person's daily records, some were on an 'Accident Report' form whereas others were on an 'Accident/Near Miss Form'. This showed there was a lack of consistency in the documenting of significant events which the manager and provider should have oversight of. Additionally, accidents and incidents which were being recorded on accident forms were not being analysed to identify any patterns that could be used to help reduce the risks to people. There had been no analysis of the day, time, location or staff members working, which could indicate a trend in why incidents were occurring. This had also been identified by the local authority in their visit. This meant there was a lack of oversight to enable improvements to be made to people's well-being and safety and feedback was not acted upon.

There was no effective system to ensure medicines were managed safely. People were not always supported safely with their medicines and medicines were not always stored appropriately. The provider's systems and processes had failed to identify this. Nurses were responsible for administering medicines. The competency of nursing staff in relation to their medicine administration had not yet been checked by the provider, despite receiving feedback that there were concerns regarding medicines and an alleged serious incident regarding medicines was being investigated. Poor practice by nurses had not been identified, such as carrying medicines through the home and not checking fridge temperatures correctly. This meant these practices had continued in the home. A new competency check had been designed, however this had not yet been used so the efficacy could not be assessed. Monthly medicines audits were carried out, however these lacked detail and it was not possible to see which person's medicines had been checked. Some areas of medicine administration were not included in the audit, such as medicines via a PEG or patches applied to people's skin. This meant improvements needed to these areas were not identified which left people at risk.

The manager had asked people, relatives and staff for their feedback about the service in September and October 2018. Multiple questionnaires had been received which included comments and suggestions for improvements. Feedback was often about the food and availability of activities for people needing improvement. However, these responses had not been fully considered and this feedback continued to be reiterated by people, relatives and staff at our visit. The manager and provider had also failed to identify that some staff were sometimes using inappropriate language to describe people who required assistance to eat. This meant insufficient action had been taken to ensure people's experience of their care improved.

These issues constituted a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notifications need to be submitted to the CQC when certain events occur in the home, such as if a safeguarding referral is made or if a person passes away. Some notifications had been submitted; however, we found some concerns that were recorded as being referred as a safeguarding concern had not been notified to us. This meant we were unable to effectively monitor the service and always check the appropriate action was being taken to keep people safe.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Following our feedback, the manager provided us with an initial action plan to address our immediate concerns. The manager and deputy manager were open to our feedback. The manager said, "We're very open and we want to be helped. I want to know where we're going wrong." However, we were unable to assess that the provider's actions had been successful in addressing the shortfalls. We will check this at our next inspection.

People, relatives and staff felt positively about the manager, but recognised it was a difficult job. One person said, "[The manager] is fair and approachable, they have a nice temperament." One relative said, "It's a hard task, I don't know how they manage. The manager has always been good to me." Another relative said, "[The manager] is very approachable, they take the worries from you. I feel more relaxed now." A visiting health professional said, "I can absolutely go to [the manager] with concerns." Staff also told us they generally felt supported. One staff member said, "I raise things with [the manager], they listen to my concerns." Another staff member told us, "I feel I can go to the manager and deputy manager easily. I can tell them anything." Another staff member commented, "They [the manager] are doing their best." The manager also told us they felt supported by the provider. They said, "The provider meets with us every week, checks if there is anything we want, tells us if there are any more trades people coming in that week. The provider is brilliant. They don't scrimp. I feel very supported; the provider phones up every day to check we're ok." Another staff member said about the provider, "They listen to what I say."

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not always managed safely. Lessons were not always learned when risks to people had been identified.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notifications regarding serious injuries and a safeguarding referral had not been submitted.

The enforcement action we took:

Fixed Penalty Notice