BKR CCH Limited

Millington Springs

Inspection report

160 Portland Road
Selston
Nottingham
Nottinghamshire
NG16 6AN

Tel: 01773863557
Website: www.millingtonsprings.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 11 and 17 December 2018; the first day of inspection was unannounced.

Millington Springs is a 'care home with nursing'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Millington Springs accommodates up to 42 people in one building. At the time of our inspection there were 18 people living at the service; seven of those people had nursing needs and 11 people had residential needs.

Millington Springs was registered with the Care Quality Commission on 12 June 2017; this is the first comprehensive inspection of the service since it was registered.

There were two registered managers in post at the time of our inspection; One registered manager was working in another location owned by the provider and was not present during our inspection of this location. The other registered manager who was available at this location during our inspection was also the registered provider. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are registered persons. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Statutory notifications for allegations of abuse had not always been submitted as required.

Risks associated with people using bed rails had not always been assessed. Some areas of record keeping for cleaning and kitchen temperature records were not always complete. This required improvement to ensure the quality and safety of services in these areas were assured. In addition, we identified where infection prevention and control practices could improve to help protect people from the risks associated with infections.

People felt the care and treatment they received at Millington Springs was safe. Staff understood and had been trained in how to keep people safe. Recruitment checks helped the provider make decisions on the suitability of staff to work at the service. Sufficient numbers of staff were provided to help ensure people were cared for safely. Other risks to people's health had been assessed and actions taken to reduce risks. Arrangements were in place for the safe management of medicines Accidents and incidents were reviewed to help identify improvements.

Care needs were assessed and focussed on achieving effective outcomes for people. Staff told us they felt supported by the management team; staff were trained in areas related to the needs of people using the service. People had access to other healthcare professionals such as GP's and speech and language

therapists. The premises were suitable for people.

People were supported to maintain a balanced and nutritious diet, however people would benefit from more choice over how their food was presented and some people may have benefitted from being able to see the food options available. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. However not all staff were knowledgeable on which people had DoLS approved.

Processes were in place to assess any specific needs associated with the Equality Act 2010 to help prevent discrimination. Information was provided in ways to help them understand choices.

Staff were caring to people and knew them well. People's independence was promoted. People were supported to maintain their relationships with their relatives and relatives felt welcome when visiting.

People contributed to their care plans and received personalised and responsive care. People had a range of activities provided at the service and were free to pursue their own interests. Processes were in place to manage and respond to complaints in an open and transparent manner.

The provider had taken steps to gather views from people, relatives and staff. Policies and procedures helped the governance of the service. Other checks were made on the quality and safety of services. Accidents and incidents were reported and action was taken to learn from events when things had gone wrong.

We found one breach of the Care Quality Commission (Registration) Regulations 2009 and one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; you can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Not all risks associated with bed rails had been assessed. Improvements were required to infection prevention and control measures. Other risks, for example those associated with fire were assessed. People felt safe, recruitment processes checked staff were suitable to work and staff were trained in keeping people safe. Sufficient numbers of staff were deployed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were treated fairly and the principles of the MCA were followed, however staff knowledge on DoLS required improvement.

People received care to meet their nutritional and hydration needs, however improvements were required to how people made choices and how their meals were presented to meet their needs.

The premises were suitable for people and met people's needs. People's health needs were assessed. People had access to other healthcare professionals. Staff were trained to meet people's care needs.

Is the service caring?

Good

The service was caring.

People's privacy and dignity was respected.

Staff were caring. People were involved in decisions about their care and support. People's independence was supported. Relatives were free to visit and people could spend their time as they chose.

Is the service responsive?

Good

The service was responsive.

People, relatives and staff were listened to. Systems were in place to manage and respond to complaints. People had a range of activities available. Information was provided in a way people could understand. Plans were in place to discuss advance care plans with people when needed.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Not all statutory notifications for abuse had been submitted as required. Some areas of record keeping required improvement.

Two registered managers were in post. The service was managed in an open and inclusive style. The service worked in partnership with other agencies.

Millington Springs

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 comprehensive inspection took place on 11 and 17 December 2018; the first day of inspection was unannounced. The first day of inspection was completed by one inspector, a specialist professional advisor whose area of specialism was nursing, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In addition, this service was selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team also included a dental inspector who looked in detail at how well the service supported people with their oral health. This includes support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019. The second day of inspection was completed by an inspector and an inspection manager.

Before the inspection visit we looked at all the key information we held about the service, this included whether any statutory notifications had been submitted. Notifications are changes, events or incidents that providers must tell us about. As part of this inspection process we also used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We also checked whether Healthwatch Nottinghamshire had received feedback on the service; they had not. Healthwatch Nottinghamshire is an independent organisation that represents people using health and social care services.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with four people who used the service and three relatives. We spoke with one of the registered

managers who was also the registered provider, the service manager, two registered nurses, a senior carer worker, two care workers, a housekeeper, the cook, a kitchen assistant and the maintenance person.

We looked at the relevant parts of three people's care plans and reviewed other records relating to the care people received and how the service was managed. These included risk assessments, quality assurance checks, medicines administration records, staff training and policies and procedures. We asked the provider to send us further information on their policies and procedures; these were received as part of this inspection.

Requires Improvement

Is the service safe?

Our findings

Some people received care to apply prescribed creams or solutions; these are called topical medicines. There are recommendations for when topical medicines should be disposed of based on the date they are opened. This helps to reduce the risks of infection as well as to ensure the efficacy of the medicine. We checked the topical medicines for four people. In total, four topical medicines, belonging to three out of the four people had no date of opening recorded. We also found duplicate prescription creams had been opened for one person. In addition, two creams for two separate people were not on a topical medicines administration record (MAR) chart. MAR charts contain the instructions for staff on when and how to administer medicines as well as recording when they have been administered, refused or are not required. Medicines should only be administered if they are on a MAR chart. This meant there was no record made of prescribed creams being offered, administered or refused for two people. Medicines were not always managed safely and in line with recommended good practice as creams were not dated when opened. People were at risk of not having their prescribed creams administered consistently as not all creams were on a MAR chart.

Risks to one person's safety had not always been assessed. This was because one person used a bed rail to reduce the risk of them falling from bed. Bed rails require an assessment to ensure they are both suitable for the person and the bed and mattress they are fitted to. In addition, the position of bed rails must meet with recognised health and safety guidance to ensure any gaps do not present a risk of entrapment to people. There was no bed rail assessment completed to show this equipment had been assessed as safe for this person to use. In addition, there was no record to show this piece of equipment had been regularly checked to ensure it remained safely positioned on the person's bed. Not all steps had been taken to assess, monitor and manage risks.

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

Bedrails require careful management and as such they should be regularly checked to ensure they are in good working order, correctly and safely positioned and that other risks associated with their use are minimised. Bedrails were in use by other people and we saw risk assessments and checks were in place. We were concerned that these did not record checks on the measurements and position of the bed rails to ensure they remained safely positioned. However, shortly after our inspection the provider sent us further information to show these checks were sufficient.

We saw other risks to people's health were assessed. For example, when people had been assessed as being at risk from pressure area damage, they had used pressure relieving cushions and mattresses to help reduce risks.

We saw risks in the general environmental risks had been identified and actions taken to help keep people safe. A fire risk assessment was in place and systems designed for use in an emergency, such as fire alarms and emergency lighting were regularly tested. Personal emergency evacuation plans (PEEP's) were in place

for each person. These showed what assistance people would require should an emergency evacuation from the building be required. Areas of the building that could present risk to people were kept secure; for example, areas where cleaning materials were stored were kept locked. In addition, routine safety checks and servicing of equipment, such as for lifts, hoists and slings, had been regularly completed.

We saw the provider completed checks on staff as part of their recruitment processes. These checks were designed to help provide assurances staff were suitable to work at the service, they included references and criminal record checks as completed by the Disclosure and Barring Service (DBS). We found one staff member had started work before the full DBS check had been received and another staff member had started work before a reference was received. The registered manager told us these staff had worked on a supernumerary basis until these checks had been completed. This meant they were additional to the number of staff required to provide care. However, the provider's recruitment policy at the time of their recruitment stated staff could only work on a supernumerary basis after DBS and reference checks had been completed. The registered manager emailed us an updated recruitment policy shortly after our inspection. This stated after an initial DBS check, staff could work on a supervised basis whilst waiting for the full DBS check and references to be received.

Staff told us they had been trained, and could explain how to identify potential abuse and how to report it. Information on safeguarding was on display in the service. Records showed the service had appropriate systems, processes and practices in place to safeguard people from abuse. When abuse was suspected the provider took appropriate action to ensure people were safe and inform the local authority. However, statutory notifications were not always submitted as required to CQC.

We saw communal areas and people's rooms were clean and tidy. Cleaning schedules were in place and records had been made of when areas of the service were cleaned. However, we found some occasional gaps in records for areas such as the sluice room. Sluice rooms should also have eye protection available for staff to help prevent infection risks. These were not available. In addition, domestic staff we spoke with did not have any knowledge of 'spillage kits' despite the service manager telling us a spillage kit was available in the sluice room. Spillage kits are designed to ensure any spillages of bodily fluids are safely cleared up. Not all steps had been taken to ensure people were fully protected from the risk of infection. Shortly after the inspection the registered manager told us domestic staff would not use spillage kits and this duty would fall to care staff. However, it is the view of CQC that all staff who may come into contact with spillages would need to be aware of the availability of any specific cleaning kits designed for this purpose.

Some other actions were taken to reduce the risk from infection. We saw staff practised good hand hygiene and this was checked by the provider to ensure staff met this expectation. We discussed with the registered manager the care of one person where improvements could have been made. We also identified improvements to catheter care to help prevent infection. These points were acknowledged and taken on board by staff and the registered manager.

People told us they received care to help them take the medicines they needed. A relative told us, "The home look after [family member's] medicines and they have never run out and it's given on time." We found medicines were stored safely and at the correct temperature to ensure their efficacy. Some medicines are required to have additional measures in place for their ordering, storage, administration and disposal; we checked these and found they were all in place and being followed. Protocols were in place to ensure people received consistent care if they required any medicines at variable times. We saw staff provided people with their medicines in an unhurried and careful manner and the purpose of people's medicines was explained to them.

People told us they felt safe living at Millington Springs. One person told us they felt safe because, "There is always somebody about." Relatives shared the view people were safe. One relative told us, "[Person] is definitely safer here than at home because there is 24/7 care."

People and relatives told us there were enough staff available to care for people. One person said, "I don't have to wait long if I use the buzzer; sometimes it takes a while in the morning, but not too long." A relative told us, "It's sufficiently staffed; they could do with more but I don't think [name of family member's] care is compromised." We saw staff were present in communal areas and responded to people in a timely way.

Staff rotas were planned and in place for care workers and registered nurses. The provider had an assessment tool to help them calculate the number of staff needed to meet people's needs, and they told us this was kept under review. In addition, the provider had planned additional shifts on a supernumerary basis for the registered nurses so they could complete all necessary tasks. We saw this in operation on day two of our inspection. The supernumerary nurse told us this enabled them to ensure all care plans were updated as well as to complete any discussions with other health professionals regarding people's care and treatment. The service had sufficient numbers of staff to support people to stay safe and meet their needs.

Accident and incident records showed lessons were learnt and improvements made when things went wrong. For example, when a person had a fall, they were observed afterwards and a referral was made to other healthcare professionals for further input. This led to improvements in the person's care. This is an example of how the provider made improvements when things went wrong.

Requires Improvement

Is the service effective?

Our findings

Meals looked appetising and well presented; however, there were further opportunities to promote people's choices. For example, one person just wanted one type of vegetable with their main dinner, however their dinner had already been plated up in the kitchen. Staff told them they would just have to eat what they wanted and leave the rest. In addition, meals were served with the gravy already poured in the kitchen; again, this did not afford any choice as to where people wanted their gravy. When dinners were served staff did not tell people what their meal was. We saw people were asked whether they would like cake or ice cream for pudding, however staff did not show or describe to people what types of cake or ice cream were available. Providing people with descriptions of food or being able to see choices of food can help to promote people's appetite.

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. 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 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met; we found that they were. The service had policies in place that covered the MCA and making decisions in a person's best interests. Care plans showed any best interest decision making was specific and had involved relatives and health professionals had been involved in the decision making process. Where appropriate, applications for DoLS authorisations had been made. However, not all registered nurses and care staff knew which people had an authorised Deprivation of Liberty in place. This is important so that staff understand any restrictions that have been authorised on a person.

People and relatives told us they thought staff were well-trained and had the skills and experience to care for them. Staff told us they received an induction and training in areas relevant to people's needs. For example, staff told us they had been trained in areas such as health and safety, infection prevention and control and safeguarding. Whilst staff had individual training records, the overall system to monitor staff training did not accurately show what training staff had completed or required. The registered manager told us they had identified the training system as an area for improvement and were currently working to improve the system to record and monitor training.

At the time of our inspection, there was no nursing clinical lead to provide clinical supervision to the registered nurses working at the service. Instead, the service manager told us registered nurses had access to group supervision meetings. The registered manager told us they were looking to recruit to a clinical lead position to help further the support to registered nurses. Supervision provides staff members with the opportunity to reflect and learn from their practice, receive personal support and professional development.

Care staff told us and records confirmed they had supervision meetings for support as well as competency assessments to ensure they met the provider's expectations in a range of areas. We saw care staffs' competency was checked in moving and handling, safeguarding knowledge, medicines competency and hand washing practice.

People had their health and care needs assessed to identify what care they needed. Recognised assessment tools were used to assess people's nursing needs and personal care needs and preferences. For example, nutrition, skin viability, mobility, falls, continence and oral health. The assessments we reviewed were personalised and comprehensive.

Staff were knowledgeable of people's diverse needs and told us how some of these needs were met. For example, how people liked to practice their faith. Staff told us they had been trained in equality and diversity and the provider's equality and diversity policies and procedures set out the provider's commitment to meeting people's diverse needs. These were up-to-date and showed an awareness of the protected characteristics under the Equality Act. The culture of the organisation was open to providing care that met people's needs without the fear of discrimination. For example, people's different sexualities were respected and the registered manager told us how they would help people celebrate events such as Gay Pride if they so wished.

People and relatives told us they were satisfied with the food. People we spoke with told us they had enjoyed their lunch and pudding. We saw families were welcome to spend time with their family members over mealtimes. When people required help from staff with their meals, we saw staff provided this.

Staff offered people choices of drinks and snacks from the tea trolley; this included choices of biscuits as well as prepared pieces of fruit for people to choose from. Where people required food of modified texture, snacks such as cakes had been prepared in this way so they were available for people to have. Information on people's dietary needs and preferences was available for kitchen staff to reference in the kitchen. Assessments were in place to ensure people at risk of malnutrition had their needs identified and met. People's weights were monitored for weight loss and gain and actions taken to help people retain a healthy weight. People were supported to maintain a balanced diet.

Registered nurses and care staff were clear on their roles and responsibilities. People and relatives told us they thought staff communicated well. One relative told us, "Staff work as a team and I only have to tell one member of staff and that message is passed on; they communicate well." Handover meetings were held when staff changed shifts to ensure important information about people's care needs transferred between staff when they changed shifts. We observed staff coming onto shift were told useful information and could ask further questions to help clarify any issues. The staff team worked well together to help ensure people received effective care.

Staff told us and records confirmed, they worked with a range of other health and social care professionals to ensure people received effective care. Records showed this had involved specialist assessments by speech and language therapists for people's swallowing function, and a dietician and specialist nutrition practitioner. People had access to other health care professionals when their advice and input was needed to help provide effective care.

Millington Springs had been adapted to meet people's needs. Corridors were fitted with handrails and a lift helped people access the ground floor and first floor. Each room was fitted with a nurse call system where people could press a button to request assistance from care staff. Additional equipment, such as toilet raiser seats were also available. Different lounge areas and rooms were also available for people to use around the

building. People's bedroom doors were decorated different colours to help people identify their room. The premises had been adapted and designed to help meet the needs of people using the service.

Good

Is the service caring?

Our findings

People and relatives told us staff were caring. A relative told us, "Staff are so caring, so professional, we trust them." Another relative showed us some gifts that staff had brought for their family member. They also showed us some photographs of a birthday celebration with a buffet for people and decorations. We saw staff talking with people and asking people, "Are you alright, are you tired?" At other times we saw staff sitting with people and relatives, sharing conversations and helping to create a pleasant and relaxed environment for people. These were examples of staff being kind and caring.

People and relatives told us they felt involved in their care and knew about their care plans. One relative told us, "We've been involved in [family member's] care plan and have given feedback about it." From reading a selection of care plans we could see these were personalised and reflected people's individual needs and wishes. The provider had taken steps to involve people in their care plans and their needs and wishes were met with respect.

People told us, and we observed staff promoted their privacy and dignity. For example, we observed staff knocked on people's doors before entering. We also observed people were offered clothing protectors over mealtimes to help keep their clothes well-presented. A relative told us, "Staff do protect [family member's] dignity." They went on to say that the personal care staff provided was done professionally and promoted their dignity. People were treated with respect and their dignity and independence were promoted.

Staff told us how they promoted people's independence, for example staff told us how some people used lidded cups to help them manage their own drinks themselves without the risk of spilling liquids. Relatives told us they visited whenever they wished and we saw relatives visited at different times throughout our inspection. One relative told us, "We come in at different times so we do see what's going off." They told us they were happy with their family member's care. People's independence and relationships with relatives were supported.

Good

Is the service responsive?

Our findings

People and relatives told us they were involved in reviews of care plans and that staff provided responsive care and support that met people's needs. One person told us they decided when they got up in a morning, when to go to bed and when they wanted a shower. We saw staff responded quickly to assist people. For example, one person requested assistance from staff as they wanted to have a lie down in their room; we saw staff respond straight away and made sure the person had everything they wanted with them. At other times we saw staff provide snacks and drinks to people's preferences.

Staff we spoke with were knowledgeable on people's histories and their likes and dislikes and this detail was reflected in care plans. In addition, people and staff told us people could do things in their own time for example, get up when they wanted and have lunch at a different time if that was their preference. Staff also told us how technology helped to remind them when people needed care at a specific time. For example, if a person required repositioning to help reduce the risk of pressure damage. The registered manager told us they would assess people's needs prior to them joining the service. These are examples of a personalised and responsive service.

People told us they were mostly content with how they spent their time. One person told us there was sometimes not much to do but that this was improving. For example, they told us, "Last night there was a choir." Another person told us staff sometimes struggled to do regular activities. The registered manager told us they had employed an activities coordinator who was not at work at the time of our inspection, however they were continuing to provide activities. For example, staff told us how a person had enjoyed playing a game with them during our inspection. Other people and relatives told us about the choir and people had clearly enjoyed this activity. One person told us, "I like to entertain myself." Their relative told us, "They prefer to spend time in their bedroom; they have a keyboard, a radio and TV." Records showed people had enjoyed a range of other activities including reminiscence, puzzles, singing and art and creative activities. A range of activities had been provided for people.

The provider had looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. Staff told us and records confirmed people were offered the chance to have information, such as their care plan or welcome pack information explained to them verbally. Staff were also aware of when people required help with their hearing aids and told us they made sure these were working for people. These actions helped to ensure information was provided in different ways so that people could understand it.

People and relatives told us when they had made a complaint or given feedback this had been dealt with to their satisfaction. Records of complaints and feedback received showed these had been comprehensively investigated and the complainant involved and kept informed. This helped to ensure any complaints were managed in an open and transparent way. The provider had a complaints policy and procedure in place to

ensure any complaints were investigated and managed and information on how to complain was on display.

The registered manager told us no one was on end of life care at the time of our inspection. However, they told us care plans for the provision of care towards the end of a person's life would be put in place when needed. They also added they were planning to speak with people and families in the near future in order to start advance care plans for people if they so wished. Staff we spoke with understood what care was needed towards the end of a person's life and told us they had been trained in this area.

Requires Improvement

Is the service well-led?

Our findings

The provider is required to submit statutory notifications to CQC. Notifications are changes, events or incidents that providers must tell us about. However, we found statutory notifications for when allegations of abuse had been made had not always been submitted when required. Prior to our inspection, we were aware of one safeguarding investigation that whilst it had not substantiated an allegation of abuse, did make recommendations for the registered manager to implement. In addition, during our inspection we found evidence of a further two allegations of abuse that had been investigated. These incidents would require statutory notifications to be submitted. The registered manager told us it was an oversight that the statutory notifications had not been submitted.

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

A registered manager is required and two registered managers were in post at Millington Springs. One of the registered managers was present at our inspection; they told us the other registered manager worked at another of the provider's locations. 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.

Records showed checks were made on the safety and quality of services. For example, on infection prevention and control measures, medicines and on areas of health and safety such as fire alarm testing. However, audits of medicines had not identified the shortfalls with topical medicines as reported on elsewhere in this report. Whilst checks on the quality and safety of services were in place, they were not always effective at identifying shortfalls.

We found most records of people's care were accurate and complete. However, we found other records such as cleaning schedules and temperature records of kitchen fridge and freezer temperatures had gaps in them. This meant checks on the quality and safety of services in some areas of the service could be compromised. Not all records were accurate or up to date.

People, staff and relatives told us they found the registered manager and service manager, who also worked at the service in a management role, approachable and helpful. One person told us, "The management always have time; they are very approachable; they will stop and give you the time if you ask them something." We observed both managers talking with people, relatives and staff throughout our inspection. Another person told us, "If staff have a problem they speak to the managers immediately; that's good; yes, it's definitely well-led."

The registered manager had taken steps to ensure people, relatives and staff were involved in the service. Records showed the service manager had regular chats with people on an individual basis. These helped to ensure the service manager obtained feedback from people about the ongoing care they received. We also saw people were asked for their views shortly after arriving at the service and this helped check how people

were settling in. Minutes of meetings with people showed people had the chance to discuss the service together; we saw people had discussed such things like the food service and activities available.

Staff told us they also were asked for their views and felt listened to. For example, one member of staff told us how their idea for the choir to visit people had been listened to and they were happy this had been organised by the service manager. Records showed a range of meetings were held with staff to ensure they understood their roles and had the opportunity to discuss different ideas. There were regular opportunities for people, their relatives and staff to be engaged and involved with the service.

Accident and incident reports were completed by staff and reviewed by a member of the management team. Records also showed action plans were implemented after the advice of other professionals to improve services. For example, after a visit by a pharmacist. This helped to ensure actions were taken to help prevent recurrence and is an example of how systems and processes were used to help improve the quality of care and learn from when things went wrong.

People and relatives told us they had access to other healthcare professionals when needed. We observed staff in discussions with GP's to ensure the best treatment plans for people. Care plans and daily notes had been updated to show the involvement and advice of other professionals, such as GP's and speech and language therapists. Training, such as continence promotion, wound care and venepuncture had also been soured from other healthcare organisations. The service worked in partnership with other agencies to ensure good outcomes for people.

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 18 Registration Regulations 2009 Notifications of other incidents (18) Statutory Notifications for allegations of abuse had not been submitted as required.

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 (12) The proper and safe management of medicines was not always in place for topical medicines. Not all steps had been taken to assess, monitor and manage risks.