Springfield Healthcare (The Grange) Limited

Seacroft Grange Care Village

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection, which took place on 18, 23 and 24 January 2018. At the last inspection in June 2016, we found two breaches of the legal requirements relating to the safe management of medicines and governance arrangements. At the last inspection we issued warning notices in respect of these breaches. At this inspection we found the provider had undertaken work to address previous issues identified with medicines management. Whilst a number of previous concerns in this area had been addressed and we saw improvements had been made, we found ongoing concerns with the safe management of medicines and governance.

Seacroft Grange Care Village is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Seacroft Grange Care Village provides residential, rehabilitation and nursing care for up to 95 people. The accommodation is set over three floors across two buildings, with a central facility which contains a coffee shop, spa, hair salon, therapy room and cinema. It is situated in a residential area of Leeds with good access to local facilities and access to transport links.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the CQC 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.

Although there had been some improvement in the management of medicines since our last inspection, there were still shortfalls in administration and recording.

There had been some improvements in the governance and quality monitoring structures at the service since the previous inspection. However, further review of quality assurance systems and governance in the service is needed to ensure improvements continue to be made especially in relation to medicine management.

People and relatives told us they felt safe and secure. Risks to people were assessed and managed appropriately.

There were enough staff to provide care safely. The registered manager monitored the number of staff required through the use of a dependency tool. Safe recruitment systems were in place to make sure staff were suitable to work with vulnerable people.

Staff were given sufficient training and support to carry out their roles effectively. Staff had access to extra training and were supported to pursue their career goals in a constructive way.

Staff demonstrated a good understanding of the Mental Capacity Act (MCA) 2005 and ensured important decisions were made within the best interest decision making process. Deprivation of Liberty Safeguards (DoLS) applications were made appropriately and staff demonstrated an understanding of this and why they were in place to protect vulnerable adults.

People's health and wellbeing was supported by knowledgeable staff who were proactive in monitoring people's health and making referrals to health professionals where necessary.

People told us they were cared for by kind and compassionate staff who supported their independence, respected their individuality and protected their privacy and dignity.

There was a wide range of activities and entertainment on offer, which took into account people's like, dislikes and personal preferences. The service had established good links with the local community and used these to the benefit of people living at the service.

There was a complaints process in place, and people told us they knew how to make a complaint. Complaints were responded to in a timely way.

There was good engagement with people through questionnaires and surveys, and evidence that people's feedback was listened to. The registered manager made themselves available to people through weekly 'surgeries', and people told us they felt confident they could raise any issues they had.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12 (Safe Care and Treatment) and Regulation 17 (Good governance). You can see what action we asked the provider to take at the end 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 always safe.

There were shortfalls in the way medicines were administrated and recorded.

There were enough staff to care for people safely. Staff were appropriately vetted before working with adults who may be vulnerable.

Risks to people were assessed and managed, and staff were trained in preventing infections.

Is the service effective?

Good

The service was effective.

Staff were well trained and supported to perform their roles.

People were supported to maintain a healthy diet and, where necessary, their food and fluid intake was monitored.

People had good access to healthcare services and staff were proactive in making appointments and seeking professional advice on people's behalf.

Is the service caring?

Good

The service was caring.

People were universally positive about staff attitude, compassion and care.

People told us their dignity was protected by staff who were also helping them to maintain their independence.

Is the service responsive?

Good

The service was responsive.

People were appropriately assessed before entering the service and had personalised care plans, which included their choices

and preferences.

There was an extensive programme of activities on offer which took into account people's interests and hobbies. People were supported to maintain an active social life and access the community.

People knew how to make complaints and complaints were investigated and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality monitoring systems were not fully embedded and there were still shortfalls in this area.

There was good engagement with people and their relatives, and feedback was acted upon.

Seacroft Grange Care Village

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 18, 23 and 24 January 2018 and was unannounced.

Before our inspection, we reviewed all the information we held about the home, including previous inspection reports and statutory notifications sent to us by the provider. We contacted the local authority and other health and social care professionals involved with the service to gather their views on the quality of the service delivered.

We 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.

The inspection was carried out by two inspectors, a medicines inspector 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.

During the inspection, we conducted a tour of the service and reviewed documentation relevant to people's care and the maintenance of the facilities, for example care plans, medicine administration records and risk assessments. We spoke with 15 people who used the service and eight people's relatives. We spoke with 12 staff, which included the registered manager, head of maintenance and facilities, pharmacist technician, quality and compliance manager, activities coordinator, senior carers and carers. We also spoke with a volunteer at the service, a visiting teacher from a local school, and a visiting healthcare professional.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in June 2017, medicines were not managed safely. We issued a warning notice telling the provider they needed to improve their medicines management by November 2017 to ensure people were given their medicines safely. At this inspection, although improvements had been made, the provider was still not meeting the legal requirements to manage medicines safely.

During our inspection, we looked at 20 people's medicines records. We found errors in the recording and administration of medicines. For example one person who was prescribed pain relief patches for severe pain had theirs given two days late without any documented explanation in their records. This issue had been identified by the service and investigated accordingly. Another person was not given their medication for three nights despite the tablets being available for administration because proper records were not in place. One person was only given half the prescribed dose of antibiotic for two days which placed their health at risk of harm. We checked the stock levels with the records of administration and found that two people were not given the correct doses of their medication and no explanation was recorded.

People were not always given all their medicines as prescribed because they were asleep, or they had refused to take them . This included medication for osteoporosis and medicines usually prescribed for dementia. When people needed their medicines to be administered covertly, there was information missing from the pharmacist about how to give all their medicines prescribed in this manner. This meant that nurses and senior carers did not have enough information to explain how these medicines should be safely administered.

As at the previous inspection, records about medicines were not always clear or accurate. During this inspection, we did some stock checks and found on some occasions medicines had been signed for, but had not been given. The quantity of medication held in the home for people was not always accurate, which meant it was not always possible to check medicines were accounted for or had been given as prescribed.

Records about creams nurses or senior care staff applied did not include information about where to apply them. One person missed having their cream applied on two nights, because this information was not recorded.

The records about the use of prescribed thickeners, used to thicken people's fluids to prevent them from choking were poor. No records were made by staff that made the thickened drinks of what they had used, and inconsistent records were made on the medication administration records. We did not see any written guidance for staff to refer to as to how to thicken drinks safely. One person was newly prescribed a thickener and one member of staff told us it was not used because the person was not coughing much. The person's care records stated it must be used in all fluids.

Some people were prescribed PRN medicines to be given 'when required'; however there was no mention in the medicines policy of PRN guidance, and in records we looked at, there was insufficient personalised information for them to be given safely and consistently. We were told by the registered manager that the

provider was in the process of writing a new medicines policy which would include this.

These findings evidence a continuing breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above continuing shortfalls, there had been some improvements made since our last inspection, and the registered manager was working towards improving the management of medicines. For example, we did not find any stock that was out of date. All opened medicines included stickers which stated when they were opened and the use-by date, which we identified as a concern at our last inspection. Medicines which required temperature control were stored appropriately and the temperatures of fridges used to store medicines were monitored regularly. The provider had recruited a specialist pharmacist technician who worked part-time at the service to address on-going concerns with medicines administration and management. They had only been in post for around four weeks at the time of the inspection. They told us they had arranged a programme of advanced extra training for staff on medicines administration. They also would start conducting independent bi-monthly audits of medicines in conjunction with the medicines audit already in place to add extra oversight and improve the analysis of trends and themes. However, as they were newly in post these actions were still in progress and there was insufficient data to analyse the impact and effectiveness of these actions.

People told us they felt there were enough staff to deliver care safely. The provider used a dependency tool to calculate the number of staff required to provide care. A new night manager had been recruited to provide additional support for the night staff whereas previous night shifts were led by the nurse with support from an on call manager. All staff we spoke with agreed there were enough staff. One member of staff said, "We have a very stable team, regular staff, but we are pragmatic when people ring in sick or go on maternity leave. If we use agency, they are regulars we know, and they ask us for feedback on how agency staff performed."

Staff were recruited safely. Appropriate background and ID checks were carried out; this included a Disclosure and Barring Service (DBS) check. The DBS is a national agency which uses the police national database to help employers make safer recruitment choices.

Staff were trained in safeguarding vulnerable adults and were able to describe different types of abuse and how they would raise concerns. For example, one member of staff described how, if they were to ever witness aggression from a family member towards a person, they would report this to the senior or manager and document what they had seen in an incident report. Staff were also aware of the provider's whistleblowing arrangements, which included a telephone number where they could discuss any concerns they had in a secure and confidential way.

Risks to people were appropriately assessed, managed and reviewed through the care planning process. Where risks were identified, there was a related care plan. These included risks of falls, pressure ulcers and malnutrition. Staff were aware of the risks people faced and they described what they did to keep people safe. This included regular position changes for people who were at risk of developing pressure ulcers.

Health and safety checks were carried out to ensure the environment was safe and that any issues would be identified. Equipment such as wheelchairs and hoists were regularly inspected and serviced to make sure they were fit for purpose. The service also carried out inspections that were considered good practice, such as portable electrical appliance (PAT) tests to make sure that electrical goods were safe.

People had Personal Emergency Evacuation Plans (PEEPS), which gave clear instructions for staff on how to

evacuate each person safely. The service conducted regular fire safety drills, and there was a comprehensive fire safety risk assessment in place. There were named fire marshals and first aiders on site at all times.

Communal areas and corridors were well lit, clean and odour-free. There were measures in place to prevent the spread of infections. For example, staff received training on infection prevention and control, and they used personal protective equipment, such as disposable gloves and aprons, when delivering care and helping people to eat. Each bathroom had national guidance posters on effective handwashing techniques and there were anti-bacterial gel dispensers on each unit. The service had experienced an outbreak of flu over the winter period, and had acted to ensure group activities were rescheduled and visitors were given information and warning to prevent the further spread of the virus.

Good

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 MCA 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. We checked whether the service was working within the principles of the MCA.

Consent was sought before care was provided and people were supported to make decisions about their care. However, some people who had been assessed as having the capacity to make their own decisions, had consent to care forms signed by their next of kin. The registered manager told us this was an oversight and made arrangements to discuss these again with the person in receipt of care and change the documentation in use.

When a mental capacity assessment showed a person did not have the mental capacity to make a certain decision, a meeting was held with appropriate parties to decide the best way forward in their best interests. For example, in relation to a person receiving personal care or living in a secure environment.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The management team had identified a number of people who needed to be assessed to see if it was appropriate to deprive them of their liberty lawfully. They had made DoLS applications to the appropriate supervisory body within the local authority. There was a system for monitoring that any conditions placed on granted DoLS authorisations were met and when authorisations were due to expire so that if still applicable new applications could be made. Records showed that new applications had been made prior to the expiry of the existing DoLS authorisation.

Staff received adequate training to meet the needs of people using the service and deliver care safely. New staff received an induction, which included an introduction to the service, training and shadowing senior staff. They were also supported during their induction period, which lasted six months, through supervision meetings where their progress was reviewed and support offered. Staff were required to complete a course of training they considered mandatory, such as fire safety, basic first aid and moving and handling people safely. These courses were regularly refreshed, and the service used a training matrix to monitor compliance. We observed that compliance rates for all courses were above 97%.

Staff told us they felt well supported through appraisals and supervisions. They told us these were a useful forum to raise issues and discuss what they wanted to achieve in their careers. There was a programme of appraisal and supervisions for the year ahead and we saw that there was high compliance with this.

Staff told us there were good opportunities for progression and they were encouraged to achieve their career goals. One member of staff said, "They are always encouraging me, they want me to be a senior. The

training is really good; there have been big changes since the new manager has come in."

The provider ensured all agency and volunteer staff were given training before delivering care and participating in activities. One volunteer told us, "Yes I was impressed with the training and they made sure I had that before I started work." We reviewed the service's file which included profiles and DBS numbers for all regular agency staff, alongside a checklist which demonstrated that they had been appropriately inducted into the service and trained.

People were supported to eat and drink enough to remain healthy and maintain a balanced diet. People told us they enjoyed the food. One relative said, "Mum is eating so much better than she was at home - she eats all the meals - she would say if she didn't like the food."

Food was visually appealing. Staff got down to eye level to help people eat in a dignified way, and presented people with two plated options to help them make decisions. On each unit, water, juice and snacks were available, and the service provided freshly baked cakes during the day. We saw staff regularly asking people if they wanted anything to eat or drink, including tea and coffee.

Staff were knowledgeable about people's different dietary needs, such as 'fork-mashable', pureed and diabetic diets. One member of staff said, "All the information is in the care plan, and for one person on my unit, we need to record everything they eat and drink so we use a food and fluid chart to do that."

The service positively engaged with people to make sure their likes and interests were taken into account. For example, the supplier held a tasting session where people were able to taste a range of dishes and make recommendations as to whether a particular dish should appear on the menu. People's religious and cultural needs with regards to food were taken into account. One relative we spoke with said, "Yes, with regards to kosher food, we were asked if there was anything they could do for us and the option was there."

People told us they had good access to healthcare professionals. Comments included, "They make all the arrangements for me to see any specialists" and, "I see the district nurse regularly - they make sure of that." Staff were proactive in making referrals to specialist services. For example, if someone's continence deteriorated, a referral was made to the local hospital, and care plans included a record of all health professional's visits. We saw in one person's care plan that after a recorded fall, they were immediately referred to an occupational therapist. One relative told us, "They never hesitate to call the doctor if necessary - and they always keep me informed - for the smallest thing."

Good

Is the service caring?

Our findings

Everyone told us staff treated them with kindness, respect and compassion. Comments included, "I am so well looked after here", "The staff provide me with lovely care and respect" and, "Without exception the staff are kind to me." One relative said, "The thoughtfulness and professionalism is second to none."

People were supported to maintain their independence. Care plans reflected what people were able to do for themselves. For example, if food was cut up, a person could eat independently. One member of staff described how they would support people to maintain their independence: "We encourage people to do what they can. For example if people can do limited things for themselves with washing, I will always say you do what you can, and I'll be just outside the door if you need me and I'll help."

People looked well cared for which was achieved through good care standards. People were clean, tidy and dressed with thought for their individual needs and style. One staff member described how a person liked their make-up a certain way and that they always helped them to apply this each day. Another member of staff said, "We don't say that we dress them, we help them to dress, and we always offer people a choice of what they want to wear."

Staff demonstrated they knew people well and were aware of their likes and dislikes. Throughout the inspection, staff engaged people who used the service in meaningful conversation.

People were treated with dignity and respect. Staff knocked before entering people's bedrooms or bathrooms and waited to be invited in. Staff treated people sensitively and with patience; they got down to people's level when helping them and gave explanations of any interactions. Staff demonstrated they understood the importance of maintaining people's privacy and dignity. One staff member said, "I treat people how I would want my mum to be treated. I make sure the doors are closed and talk people through it if I'm helping them to wash. I always make sure to gain consent." A relative we spoke with said, "Mum receives such dignity here."

The provider made sure there was information available about how to access support from external agencies and how to access an advocate. An advocate is someone who supports people to make decisions or helps make decisions on their behalf if they lack mental capacity. We saw evidence for example that an advocate was recorded as present at a person's 'best interests' meeting, which demonstrated the provider understood the advocate's role.

The service retained letters of thanks and compliments. One compliment read, 'We feel that without this loving and caring atmosphere mum may not have been with us. I thank you for the professionalism of staff and management.'

Good

Is the service responsive?

Our findings

People's needs were appropriately assessed before they moved into the service so that staff could ensure their needs could be met. The assessment included information on people's social contacts, medical history, cultural needs and interests.

Care plans were personalised and contained information about the person's preferences and choices. A person-centred document called 'This is me' was completed by people who used the service or their family members. This enabled staff to get to know people as individuals and contained information on people's past history. The care plans were detailed and gave a good account of the person as an individual, their preferences and routines. For example, every medicines care plan included information on how exactly people wanted their medicines to be administered. One care plan read, "I like staff to pour my tablets into my hand and I will swallow them with water."

Care plans were regularly reviewed and also in response to a change in circumstances, for example, a deterioration in mobility or new medical condition. People and their relatives told us they were regularly involved in the writing and review of their care plans. One person commented, "It is so important that I let them know what I need."

People's preferences regarding their end of life care were clearly recorded. This included their cultural and spiritual needs and who was involved in decision making. If people had not wished to discuss end of life care, this had been recorded sensitively in their care records.

There was a good range of activities available to people, which were tailored to people's interests and preferences so that they could plan appropriate events. For example, working age adults were provided with a monthly lunch, which included a presentation on what activities they had done in the previous month, what events and activities were coming up in the local area, and a discussion on what they wanted to do. In October 2017, the presentation included photographs of a recent trip to the coast.

During our inspection, we saw a wide variety of events taking place which were well attended and visibly enjoyed by those taking part. These included a singer, hairdresser, arts and crafts and a visit to the service by a group of children from a local primary school. People were universally positive about the activities available and the 'wellbeing' team who organised them. Comments included, "The young school children come every week and we do crafts and activities together - it is wonderful", "I love the singers and entertainers - we can have a little dance - I love that" and, "I love going over to the pub - they welcome us with open arms." This demonstrated the service had good links with the community and used them to benefit people living at the service.

Other activities included visits to local parks and museums, visits from a 'pat dog' and also events which took into account people's religious and cultural interests. For example, aside from Christmas events, such as a pantomime and decoration competition, there was an event celebrating Hanukkah for Jewish people living at the service. People agreed the service took into account their spiritual and cultural beliefs. One

person said, "I love it that the staff support me in my church activities, it means so much to me."

The wellbeing team sent out weekly rotas, and relatives told us they were very satisfied with the events and activities, as well as communication from the wellbeing team. Comments from relatives included, "Everybody receives a copy of the activities calendar - so that you can make your choices", "The staff put so much effort into making events fun and special, they know my [relative] so well" and, "The level of activities on offer is so important, it maintains links with the local community."

The service had effective systems in place to deal with complaints. Complaints were responded to appropriately and in line with the provider's policy on when responses and investigations should be completed. People were provided with good information on how to make a complaint if necessary and they told us they were confident about how to raise a complaint. One person said, "The manager is easy to talk to, you can talk to her about anything." Another person said, "If I had a problem I would go straight to the manager, they would sort it." A relative we spoke with said, "The manager has made it clear that if we had any concerns, we must tell them."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection, the service's quality monitoring systems were not always effective at identifying underlying shortfalls and trends and themes. There had been improvements in the governance and quality monitoring structures at the service and these have led to improvements since the previous inspection. However, the provider did not identify some of the issues found at this inspection in relation to medicines management.

The service had recently recruited a 'quality and compliance manager' for the service. We saw evidence that there were quality monitoring systems in place, and that the senior leadership team were analysing trends, themes and lessons learnt. For example, all incidents and accidents were analysed on a monthly basis, which showed how many accidents occurred on which unit, and what type of accidents they were. There were clear actions in place as a response both to serious incidents and any trends identified in general, with a responsible individual named to complete the action and in an appropriate timeframe.

Other audits included infection control monitoring and health and safety checks. The registered manager conducted daily 'walk-arounds' where they checked all areas of the environment for cleanliness and observed staff practice, and any actions identified were followed up. We also saw improvements in the communication of any themes identified to staff. For example, they had identified skin tears as a concern and used daily meetings to disseminate this to staff. One member of staff said, "There's been more paperwork and lots of change, we get more information and better communication."

However, in the support provided with people's medicines quality monitoring processes still required further efforts to ensure improvements made since the last inspection were sustained. Audits of medicines administration records (MARs) were carried out regularly on each unit. We reviewed audits where there were shortfalls in practice, such as issues with the recording of PRN protocol medicines. When a shortfall was identified, action had been taken. For example, individual staff responsible were given extra training and supervision, or more serious actions were taken such as removal from medicines administration until competency checks had been passed. However, it was clear from our review of medicines administration and the issues we have identified at this inspection, that further work is required to ensure improvements already made are sustained and fully embedded in practice.

We concluded that the above evidence demonstrated a continuing breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they felt the pharmacist technician who had been recently appointed would be used to add an independent level of scrutiny and drive improvement in this area. It was intended they would conduct further audits of medicines records, arrange and oversee training in medicines and, during our inspection, we saw them speaking with staff and observing practice. The service had also recruited a quality and compliance manager in July 2017 who was supporting the registered manager in improving governance and quality monitoring at the service.

At the time of the inspection, there was a registered manager in post. They had been in place since June 2017 and staff told us they had seen a positive impact. Staff felt well supported by the management team and said there was an open and positive culture. Staff told us they felt confident in the leadership of the service. One staff member said, "I absolutely love my job, I get all the support I need." Another member of staff said, "Things weren't brilliant before, but things are looking up for the better now. You get more help and support and it's made the job much more fun." The registered manager made themselves visible by conducting daily walk arounds, making notes on the environment and standards of care they witnessed. One member of staff mentioned that this had had a positive impact on them. Staff we spoke with felt the registered manager was approachable and supportive.

The registered manager also provided a weekly 'surgery' where they made themselves available for people, staff and relatives to talk about any issues they wanted to raise. One relative said, "We have taken advantage of the 'managers surgeries' - they are a good opportunity to discuss matters and it gives us confidence that the managers are listening."

Staff told us they were engaged with positively by the management of the service. The manager hosted daily 'huddles' with senior staff and team leaders to discuss any key issues or news. We observed part of a huddle and saw staff discussed residents with new health concerns and hospital appointments. The senior care staff then shared this information with care staff through noticeboards in secure areas and staff rooms as well as verbally, and staff told us this was a robust system. One staff member said, "When the seniors have huddles they write things on the notice boards and seniors tell us what is going on. For example there was an outbreak of flu on another unit so they were shutting the bistro."

There was extensive engagement with people and their relatives and evidence showed that feedback was acted upon. These included residents and relatives meetings, questionnaires and surveys. People and relatives were positive about engagement and told us they felt listened to. One relative said, "I go to all the meetings - it's the best way to get your views heard - they are good at listening to relatives." Another person said, "We get questionnaires about the service regularly." A 'You said, we did' board was available in the service with information on how issues brought up through meetings had been acted on.

People who used the service were also invited to attend interview panels to discuss their care with prospective new members of staff and give feedback to the rest of the panel which was taken into consideration. This showed a positive commitment to involving people in the running of the service.

The service had good community links with local organisations such as religious groups, local schools and healthcare services. The service hosted a regular dementia café which was open to members of the public.

The service met its obligations to submit notifications of incidents to CQC and to display the service's last inspection rating within the home and online.

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 Although there were improvements in medicines management there were continuing shortfalls in the way medicines were recorded and administered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not effectively identifying and addressing continuing shortfalls in medicines management.