Mr Gerald Hudson and Mr Keith Sidney Dobb

Milford House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 16 October 2014 and was unannounced.

Accommodation for people who require nursing or personal care is provided at this location for up to 65 older adults, some of whom were living with dementia and a small number of people receiving end of life care. Milford House comprises of two dedicated units - Milford House and The Coach House. At the time of our visit a total of 59 people were living in the home. This included 27 people receiving nursing care, who were mostly accommodated in the Coach House unit and 32 people receiving personal care who were accommodated in the Milford House unit.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

We found that some people's medicines were not always safely managed. This meant they were not fully protected from risks associated with unsafe medicines practices because their medicines were not always properly stored, recorded or given.

The arrangements for the planning and delivery of people's care did not always protect them against the risks of receiving inappropriate care or treatment. Care staff did not always fully understand people's care requirements relating to their health conditions and needs because people's care plans did not always provide sufficient information about this for people's care.

People were not always protected against the risk of care being provided without the appropriate consent or authorisation of a relevant person. The Mental Capacty Act 2005 (MCA) was not always being followed for some people who were unable to consent to, or make specific decisions about their care and treatment, and where decisions were being made about this in their best interests.

The provider's checks of the quality and safety of people's care did not fully protect people from the risks of unsafe or inappropriate care and treatment.

People's care plans and medicines records were not sufficiently robust to fully protect people against the risks of unsafe or inappropriate care and treatment. This was because accurate records were not always kept so that staff could easily follow them.

Staff treated people receiving end of life care with care and compassion and nursing staff were familiar with and tried to ensure some of the known good practice priniciples for this. However, the provider's end of life care strategy and policy did not show best practice standards for staff to follow, or fully inform people about the care they should be able to expect to receive.

Most people received their medicines as prescribed and records were kept of medicines received into the home and given to people. We observed that staff gave people their medicines in a safe way that met with recognised practice. Action was being taken to improve reporting procedures for staff to follow, in the event of any medicines errors.

One person's freedom was being restricted in a way that was necessary to keep them safe. The restriction, known as a Deprivation of Liberty Safeguard (DoLS), was formally authorised by the relevant local authority responsible for this.

People using the service, their representatives and staff were informed about how to recognise and report abuse. The registered manager took the action required to notify us and the relevant authorities of the alleged abuse of some people using the service. Subsequent investigations showed that people had not been subjected to any harm or abuse and that they had received the care they needed.

Staffing levels were considered and determined in a way that helped to make sure they were sufficient for people's care needs to be met. Staff mostly received the training and support they needed and there were robust arrangements for staff recruitment. Further staff training was planned relating to people's health conditions and a medicines checking procedure.

People's care records showed potential or known risks to their safety and their written care plans usually showed how those risks were being managed and reviewed. Staff mostly understood and followed these, which helped to minimise risks to people's safety. The provider's emergency contingency arrangements and reports from local fire and environmental health authorities showed that people were being protected from related risks to their safety.

People were safely supported to eat and drink and they received adequate nutrition. Overall, people were satisfied with the meals provided and the improvements that were being made to the quality and choice of meals. People's health and nutritional status was regularly checked and staff consulted with external health professionals and followed their advice for people's health care needs when required.

Staff communicated well with people and listened and acted promptly on what they said and when they needed them. Staff supported people in a gentle and caring manner and met their dignity, privacy and independence needs. Staff understood and supported people to

Summary of findings

maintain relationships with people that were important to them. People were also supported to maintain their preferred daily living routines and lifestyle interests and preferences that were important to them.

Overall, people were positive about the management and running of the home. Managers and senior staff were open and visible to people throughout the home. Communication and reporting procedures for people's care were mostly sufficient and understood by staff. Action was being taken to review a reporting procedure, following an unnecessary delay in the reporting of a medicine error.

Staff understood their roles and responsibilities and the provider's aims and values for people's care. People, their relatives and staff were regularly asked for their views about the care provided and knew how to raise any concerns about this. Staff were informed about any improvements that were needed for people's care and the reasons for them. Improvements were usually determined from the provider's checks of people's care or from comments, complaints and other relevant feedback they received about the service. Some improvements were planned or in progress. These related to people's continence care, dignity in care, medicines and cleanliness and infection control.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to a number of breaches 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Some people's medicines were not always safely managed.

People were safeguarded against the risks of abuse and known risks to people's safety were usually identified and managed. There were sufficient staff to meet people's needs and the arrangements for staff recruitment were robust.

Requires Improvement

Is the service effective?
The service was not always effective.

The Mental Capacity Act 2005 was not always followed for people's consent to their care. People were not always protected against the risk of care being provided without the consent or appropriate authorisation of a relevant person. Arrangements for the planning and delivery of people's care did not always protect them from the risks of receiving inappropriate care or treatment.

People's nutritional needs were met and staff were trained, supported and supervised for their role and responsibilities.

Requires Improvement

Is the service caring?
The service was not always caring.

People received end of life care that was caring and compassionate. However, the provider's end of life care strategy and policy did not fully enable best practice standards, or inform people about the care they should be able to expect.

Staff consulted with people and supported and communicated with them in a gentle, caring manner when providing care. Staff understood the provider's aims and values for people's care, which helped to ensure that people's dignity, privacy and independence was promoted.

Requires Improvement

Is the service responsive?
The service was responsive.

Staff acted promptly when people needed them. Staff supported people's preferred daily living routines and choices and people were supported to maintain contact with family and friends. People and their representatives knew how to raise concerns or make a complaint and they were regularly asked for their views about their care. These were listened to and acted on when required.

Good

Summary of findings

Is the service well-led?

The service was not always well led.

The providers checks of the quality and safety of people's care and related records, did not fully protect them from the risks of unsafe or inappropriate care and treatment.

Staff understood their role and responsibilities for people's care and were confident to raise any concerns they may have about this. The provider often sought people's views about the general running of the home and any improvements that were needed. Some actions were being taken to improve people's experience of their care, which staff knew and understood.

Requires Improvement

Milford House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

Before our inspection we reviewed information that was gathered about the service. This included notifications and the provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. A notification is information about important events, which the provider is required to send us by law. We also spoke with the local authorities responsible for contracting and monitoring some people's care at the home.

This inspection took place on 16 October 2014 and was unannounced. The inspection team consisted of two inspectors, a pharmacist inspector and a specialist advisor with experience of palliative and end of life care.

We spoke with 10 people who lived in the home, five people's relatives, three registered nurses, nine care staff and a visiting health worker. We also spoke with the registered manager and a senior manager for the provider. We observed how staff provided people's care and support in communal areas. This included use of the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help us understand the experience of people who could not talk with us. We also looked at 16 people's care records, 17 people's medicines records and other records relating to how the home was managed.

Requires Improvement

Is the service safe?

Our findings

Before this inspection we received information about two separate incidents where serious medicines errors had occurred for two people receiving end of life care at the home. Subsequent investigations by the relevant local authorities concluded that no direct harm had resulted from these. However, they found record keeping omissions and a reporting delay in relation to one of the incidents.

At this inspection we found that a some people's medicines were not always safely stored, administered at the correct times or recorded accurately.

One person had not received all of their prescribed medicines, as there was no supply available in the home for them to have. They had been without six of their regular medicines for the previous six days and one of those had been missed for the last 16 days. Staff were able to show us that they had ordered the medicines but could not show that they had taken any action after this to enable the person to have their medicines. Whilst action was taken following our inspection to rectify this, the person had been placed at unnecessary risk because they had not been given their medicines when they needed them.

Some people had been prescribed medicines that were to be given to them when they required them, rather than at regular intervals. For example, for pain relief or agitation. Some people were not able to ask for these medicines because of their medical conditions. Written instructions known as medicines protocols, that are required to show nursing staff how and when to give medicines prescribed in this way, were either not sufficient or did not exist. This increased the risk of staff not giving the medicines to people in a consistent way.

A few people were not fully protected against being given medicines that they were allergic to because of recording discrepancies about this. This was because the information recorded about this in people's medicines administration records and their related care plans, did not always match. People's medicines were not all securely stored. A medicines refrigerator was left unlocked and people's prescribed creams were openly left out in a communal area. This meant they were accessible to other people, visitors or staff not authorised to handle people's medicines. Controlled medicines were stored and recorded correctly, but stock checks of these had not been carried out since late August 2014, which did not meet with the provider's own policy or recognised best practice for this.

We found that the registered person had not protected people against the risks associated with the unsafe management of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people said they received their medicines when they needed them. One person told us, "Staff look after my medicines and remind me when they are needed; that's best for me." We found that most people received most of their medicines as prescribed and records were kept of medicines received into the home and given to people. People's medicines administration records sheets (MARs) were all accurately maintained and showed that people's medicines were being given as prescribed or the reasons they had not been given when required. We observed a nurse giving people their medicines. This was done safely and in a way that met with recognised practice. Medicines requiring cool storage were being stored at the correct temperature, which meant they would be effective

People were informed about how to recognise and report abuse. People told us they felt safe in the home. One person said, "I have lived here for a long time; I have always felt safe."

Staff knew how to recognise and report abuse and told us they were provided with guidance and training, which the provider's staff training programme reflected. Since our last inspection, the registered manager had notified us of any alleged or suspected abuse of a person using the service and also the action they were taking to protect people when required. This helped to safeguard people from harm.

Overall, staff and people using the service felt that staffing levels were sufficient for people's care needs to be met. Management records showed that staffing levels and absences were regularly checked and staffing levels were determined against a range of considerations, such as people's dependency levels and their care and support needs . This helped to make sure that staffing levels were sufficient to meet people's care needs. During our visit we

Requires Improvement

Is the service safe?

saw that people's care needs were met by staff in a timely manner**.** The manager told us that recruitment to two vacant care staff posts was in progress. Staff described robust arrangements for their recruitment and related records that we looked at showed this.

People's care records showed that potential or known risks to their safety were identified before they received care. People's care plans showed how those risks were being managed and they were regularly reviewed. For example, this included risks from falls, infection, pressure sores, poor nutrition and relating to people's skin care and mobility needs. Staff understood and followed these, which helped to minimise known risks to people's safety. For example, one person was assessed as being at high risk from falls. Their care plan showed the actions that care staff needed to follow to reduce or prevent further falls. The person's daily care record and care plan reviews showed that the plan was working.

We found that contingency arrangements were in place for staff to follow in the event of a foreseen emergency, such as a fire alarm. This included emergency evacuation plans for each person receiving care. The most recent reports from the local fire and environmental health authorities following their visits to Milford House showed satisfactory arrangements for fire safety precaution and very good arrangements for food hygiene and food handling.

Requires Improvement

Is the service effective?

Our findings

Before our inspection, the local authorities responsible for commissioning and safeguarding people's care in the home, told us about their investigation findings into concerns that people's health care needs were not being met at this service. They found that people's health care needs were mostly being met. However, they found significant record keeping omissions in relation to people's health care needs, which increased the risks of people receiving unsafe or inappropriate care. This included wound and continence care.

At our inspection, we found that care staff did not always fully understand people's care requirements, relating to some of their medical health conditions. We found that information about five people's health conditions, how they affected them and their related care and support needs, were not always included in people's care plans. For example, written information provided by external health professionals showed that one person had Parkinson's disease. Staff providing the person's care did not know this and it was not included in their written care plan. Another person's care plan did not identify how staff needed to communicate with them, relating to their sensory and dementia care needs. Another person's oral care needs were referred to as 'being required,' in three of their care plans. However, there was no instruction for staff to follow about what or how often and their daily care records were not completed consistently to show this. Two staff gave us different views about the person's oral care needs.

Staff told us about one person who was living with dementia and how this sometimes affected their behaviour and capacity to co-operate with their care. Staff described this as "difficult to manage," and the person's daily care records showed when this occurred. One care staff member told us about specific environmental circumstances, which they felt sometimes triggered the person's behaviour changes and the care interventions that sometimes helped. However, there was no written care plan in place for staff to follow and to help them understand and prevent this from happening where possible. The same person's care plan for their communication needs stated they were 'not always able to express their needs', but did not include details of how this should be addressed or what this meant for the person's care. The staff member also told us about other, more recent changes in the person's behavioural care needs. These were not identified in their written care plan, as it had not been reviewed to reflect those changes.

Some care staff we spoke with felt that people's written care plans did not always provide them with sufficient information to follow for people's care. All of the care staff we spoke with showed a general understanding of how dementia could affect people, but did not know about the different types of dementia and what these might mean for people's care.

We found that the registered person had not fully protected people against the risk of receiving of inappropriate care. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most of the staff we spoke with had received training about and were aware of the key principles of the Mental Capacity Act 2005 (MCA). However, staff did not always follow this when required. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves to their care, or make specific decisions about this. Many people were not always able to consent to their care because of their health conditions, such as dementia or relating to their end of life care needs. Six people's care plans had no mental capacity assessments or best interest discussions recorded, relating to decisions that they were not able to make about their care and where decisions were being made in their best interests. Three people's records of advanced decisions made in their best interests for their treatment, in the event of their sudden collapse, did not show the rationale for not consulting with them. One was completed by the clinical nurse lead employed at the service, which also did not provide a valid reason for the decision. Two were completed by external health professionals concerned with the person's care and treatment. This meant that people were not always protected against the risks of care being provided without the appropriate consent or authorisation of a relevant person.

We found that the registered person had not protected people against the risk of care being provided without the consent or appropriate authorisation of a relevant person. This was a breach of Regulation 18 of the Health and Social

Requires Improvement

Is the service effective?

Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us about one person who was not able to consent to their care, whose freedom was being restricted in a way that was necessary to keep them safe. Records showed that this restriction, known as a Deprivation of Liberty Safeguard, was formally authorised by the local authority responsible for this. The registered manager also showed us an application they had submitted to the local authority for an extension to the authorisation, which was time limited. This showed that proper steps had been taken to ensure that the restriction to the person's freedom was appropriate for their safety needs and legally authorised.

People and their relatives told us that they were satisfied with the care provided. One person receiving care told us about the arrangements made by staff for external health professionals to review their equipment, because of changes in their mobility needs. They said, "They are making sure I get what's right for me; they know it's is important to me." Two people's relatives told us about the nursing care provided to one person, which they described as being appropriate to the person's needs. One of them said, "We are happy with her care; staff make sure she's free from bed sores."

People's care files showed that advice from external health care professionals was sought when required. For example, for people's wound and nutritional care. We looked at four people's wound care and treatment plans and discussed them with nursing staff responsible for providing this care. This showed that staff understood the actions that needed to be taken to help people's wounds to heal and prevent further deterioration. Records showed that people's wound care and treatment plans accounted for the care they needed and that they were being followed and were effective.

People said they enjoyed the meals provided. One person said, "There's always a choice and plenty." Some people had a reduced appetite or difficulty eating and drinking. We saw that staff supported people to eat and drink and helped them to maintain a nutritious diet. People's care records showed that staff followed advice from external health professionals when required. For example, by providing food and drink in the appropriate consistency, to help people who had chewing and swallowing difficulties. People's care plan records showed that their body weights were regularly checked. The clinical lead nurse had completed recognised training to enable them to carry out initial assessments of people's ability to chew and swallow their food safely. This also helped them to determine whether a referral to an appropriate external health professional was necessary for further advice about people's nutrition.

Staff said they received the training and support they required to meet people's needs. Related records further supported this and included medicines training and competency checks for all staff responsible for people's medicines, with further checks planned. A few care staff told us they would like further training about people's health conditions, such as diabetes, pressure sore prevention and end of life care. The provider's training plan up to March 2015 included this and other health related conditions, such as Parkinson's disease.

Requires Improvement

Is the service caring?

Our findings

Before our inspection, the provider told us that they provided end of life care for people. At this inspection, the manager told us they were developing their own care pathway for people's end of life care. Since the previous care pathway they used, had been withdrawn from use nationally. However, their end of life care strategy and policy, did not fully enable best practice standards, or fully inform people about the care they should be able to expect to receive. For example, the arrangements for communication and information, specialist palliative and last days of life care and support for staff and families, including bereavement support for after death. Consequently, the assessment, planning and review arrangements for people receiving end of life care, did not fully ensure that their end of life care would meet with recognised best practice for this. People's written care plans included limited information about people's end of life care wishes and preferences, which may result in them receiving care in a way that may not be in line with their wishes and preferences.

The clinical lead nurse was able to describe the good practice principles for people's last days of their end of life care. There was also a supportive care register in place, to help staff anticipate people's end of life care needs. Anticipatory medicines were subject to people's assessed needs and were provided for one person whose care we looked at. Anticipatory medicines are prescribed to enable prompt relief at whatever time, should a person develop distressing symptoms associated with end of life care. This meant they could be given to the person at any time they needed them because of significant distress or discomfort. This also helped to avoid unnecessary hospital admission and enabled them to remain comfortable in the home.

People and their relatives told us that staff were caring, kind and respectful and ensured their dignity, privacy and independence when they provided care. One person said, "Staff are kind and caring; I wouldn't stay here if they weren't." One person receiving end of life care told us, "My care is very good, I have a very special bond with my care worker." People's friends and family were able to visit them without unnecessary restrictions. The relative of one person receiving end of life care told us, "Staff are caring and compassionate; they make sure that she is comfortable and pain free."

We observed that staff spent time with people and they were respectful and caring in their approach. Staff took time to explain what they were doing and gave people the time they needed to complete their daily living tasks. Staff promoted people's dignity, privacy and independence when they supported people in communal areas. For example, supporting people with their meals, mobility and medicines. Some people needed special equipment and staff support to help them with their mobility. We observed staff helping people in this way and saw they were sensitive to people's needs and abilities. This meant that people were supported to maintain as much of their independence as they were able. When equipment, such as a hoist, was needed to help people to move, staff took time to explain what they were going to do and also what the person needed to do to enable this to happen safely.

People and their relatives said that staff discussed and agreed care with them and that they were included in any formal reviews about their care. Staff understood people's rights, and their choices and preferences for their care and the right to experience a dignified and pain free death, if receiving end of life care. Information was displayed for people about their right to dignity in care and what they could expect from staff to ensure this. Information was also provided for people about external advocacy and support services they could access.

The home had a staff champion for dignity in care and had previously received an award for this by the local authority. A senior care staff leader had also won a nationally recognised leadership and care award. The registered manager told us about their plans to improve people's dementia care experience against recognised best practice. The registered manager had undertaken specialist training in this area and regularly attended external professional networking meetings relating to this.

Good

Is the service responsive?

Our findings

People and their relatives said that staff responded promptly when they needed them and that they listened and acted on what they said. One person said, “Staff are very good, I don’t have to wait too long before staff help me when I ask them.” During our inspection we saw that staff responded promptly when people needed their assistance.

People said that staff discussed their care with them and upheld their daily living preferences, routines and choices. For example, one person told us they often preferred to stay in bed to watch TV in a morning and have breakfast in bed, which staff supported. One person was not able to go out, because of their health condition, which affected their appetite. Staff went out to fetch the person a takeaway meal, when they said they would like this. People’s care records showed many of their known choices and preferred daily living routines for their care. For example, relating to their religious beliefs and disability needs. Staff spoken with had a good understanding of these.

We saw staff supporting some people, who had significant dementia care and communication needs. This was done gently and often received good responses from people. For example, one person became upset and agitated, but because of their health condition, they were having difficulty expressing why. Staff understood that the noise level in the lounge was upsetting them, so they encouraged and supported the person to go outside for a walk in the gardens. Staff explained that the person often liked to do this and that it usually helped them to feel calmer. After the walk, staff supported the person to return to the dining area for a drink and we saw that the person was smiling and calm in their mood.

People said their family and friends were able to visit at the times which suited them. People’s needs assessments and care plan records informed staff about personal and familial relationships that were important to them. They also detailed people’s preferred daily living routines and lifestyle interests and preferences. People were supported to engage in these and to maintain their contacts with families and friends as they chose.

Many people said that they enjoyed engaging in the seasonal celebrations, in house entertainers and fund raising events that were often organised. Trips to a local school had proved popular with some people who said they enjoyed meeting and engaging with pupils there. Information and photographs displayed around the home also showed that activities were regularly organised. Recent activities and events included regular gentle physical exercises, massage therapy, a slide show, a boat trip, communion services and a coffee and cake morning. Individual activities were provided to support the needs of some people with dementia. For example, sensory activities, such as massage and music and reminiscence.

People said they knew who to speak with if they were unhappy or had any concerns about their care. One person told us about a concern they had raised with the manager, which they said was dealt with to their satisfaction. Information about how to complain was visibly displayed in a large print format and could be made available in other formats to suit people’s needs. A record of complaints showed that complaints and concerns were properly recorded and acted on.

Requires Improvement

Is the service well-led?

Our findings

Before our inspection, local commissioning and environmental health authorities told us about their investigations of some people's care at the home; following concerns that significant harm or injury may have occurred to some people in relation to their health and medicines needs. The findings of their investigations did not substantiate these, but found that related records were not always sufficient to account for people's care and treatment.

At our visit, the registered manager told us that regular checks were carried out of the quality and safety of people's care and the environment. This included checks of people's health status, medicines arrangements and check of people's clinical care needs and the equipment being used for their care. They also included checks of staffing arrangements, staff training and nursing staffs' professional registration status. However, we found that the provider's checks of the quality and safety of people's care did not fully protect people from the risks of receiving unsafe or inappropriate care and treatment. This included some of their arrangements for people's medicines and for obtaining and acting in accordance with people's capacity to consent to their care. We also found that people's care records relating to their health conditions and medicines needs were not always sufficiently robust, as they were not always accurately or consistently maintained so that staff could easily follow them.

There was a registered manager in post. People were positive about the management and running of the home and knew and understood the roles of staff who led and provided their care. One person said, "The manager is always helpful." Another person's relative said, "The manager is approachable and will always deal with anything we raise."

The provider regularly sought the views of people using the service and their relatives and staff, about the care provided at Milford House. We saw that the provider used a written questionnaire to ask people and their relatives for their views about their care and accommodation. Results shared with people following the September 2014 questionnaire, showed that people were mostly satisfied with the service and a few areas, which they felt could be improved on. A plan was devised from this, which showed the actions that needed to be taken, the timescales they were to achieved by and who would be responsible for the actions.

People told us about some of the changes that were either made or being made as a result of their expressed views. This included meals, laundry arrangements and improving people's access to the local and extended community.

There was a defined governance and management structure in place, together with communication and reporting procedures, which staff mostly knew and followed. Action was being taken to review a reporting procedure, following an unnecessary delay, which had occurred in relation to the reporting of a medicines error.

Staff understood their roles and responsibilities and the provider's aims and values for people's care. Senior management and nursing staff were visible and available to staff and people using the service and those with an interest there. Staff were confident to raise concerns if they witnessed any poor practice or unacceptable care and the provider's procedures supported them to do this. This included a staff whistle-blowing procedure. This meant that staff could report any concerns they had if needed.

Staff said they received regular supervision and support from managers or senior staff, who held regular meetings with them. Records, including recent staff meeting minutes, showed that staff were asked for their views about people's care. They also showed that staff were informed about any improvements that were needed and the reasons for them, which staff that we spoke with knew and understood. These related to people's continence care, dignity in care, medicines, and cleanliness and infection control.

The provider had sent us written notifications about important events that happened in the service when required. For example notifications of any deaths in the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 The registered persons were not fully protecting people against the risks of unsafe care and treatment because people's medicines were not always safely managed. Regulation 12(1) & (2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered persons arrangements for the planning and delivery of people's care did not always account for people's health conditions and associated needs to be fully met. Regulation 9(1) (a) & (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered persons did not always protect people against the risk of care being provided without the appropriate consent or authorisation of a relevant person. Regulation 11(1).