Care Quality Commission

Buckland Care Limited

Inglefield Nursing Home

Inspection report

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Ratings

Overall rating for this service	**Good**
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?	**Good**

Overall summary

This inspection took place on 6 and 8 October 2015 and was unannounced. Inglefield Nursing Home provides accommodation for up to 43 people who have nursing care needs, including people living with dementia. There were 42 people living at the home when we visited.

There were two registered managers in place who had shared responsibilities for running the home. 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.

Some aspects of the service compromised people's safety. Infection control procedures did not always follow best practice guidance and the provider was unable to confirm that cleaning had been completed effectively. The recording of medicines administered or creams applied was not always accurate. Checks had not identified that the thermometer used to monitor the

Summary of findings

temperature of the medicines fridge was faulty. Action had not been taken to reduce all risks posed by the environment, including an internal ramp that was too steep; trip hazards in corridors; a flight of steps in the garden; and unattended cleaning products. An alarm mat had not been put in place for a person who needed it, which put them at risk of falling.

All other risks to people's safety were assessed and managed effectively. People told us they felt safe and staff knew how to identify, prevent and report abuse. Suitable plans were in place to deal with foreseeable emergencies. There were enough staff to meet people's needs at all times and recruitment procedure helped ensure only suitable staff were employed.

People received effective care from nursing and care staff who were suitably trained. New staff received effective induction to the home and all staff were appropriately supported in each of their roles. Staff followed legislation designed to protect people's rights and freedom. They sought consent from people before providing care and acted in people's best interests at all times.

Most people were satisfied with the quality of the food which was varied and nutritious. People were encouraged to eat and drink and were given appropriate support when needed. People had access to healthcare professionals and were referred to health specialists when needed.

People were cared for with kindness and compassion and we observed positive interactions between people and staff. Staff knew people well and used their knowledge of people's lives and backgrounds to strike up meaningful conversations and build relationships.

Staff encouraged people to remain as independent as possible and they protected people's privacy and dignity at all times. People were encouraged to make choices, including whether they wished to receive care from a male of female member of staff and their choices were respected.

People (and their families where appropriate) were involved in assessing, planning and agreeing the nursing care and support they received. Family members were kept up to date with any changes to their relative's needs.

People received flexible, personalised, care from staff who understood and met their needs well. Care plans provided comprehensive information about how people wished to receive care and support. Staff understood the needs of people living with dementia who had difficulty expressing themselves verbally. Best practice guidance was followed in relation to the care of people with diabetes.

Staff encouraged people to take part in a range of activities designed to meet their individual needs and interests. Feedback from people and relatives was sought and had led to changes in the way the service was provided. There was an appropriate complaints policy in place, which people were aware of.

People liked living at the home and felt it was run well. Staff understood their roles and worked well as a team. Good use was made of 'support nurses' which gave qualified nurses more time to provide nursing care. The registered managers were supported appropriately by the provider and had access to best practice guidance.

There was an open and transparent culture; visitors were welcomed and staff were encouraged to express their views. A range of audits were conducted to assess, monitor and improve the quality of the service.

We identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the 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 risks relating to the control of infection, the management of medicines, the environment and the prevention of falls were not always managed safely.

Other risks to people were managed effectively. People were protected from the risk of abuse.

There were enough staff to meet people's needs and recruitment practices were safe.

Requires improvement

Is the service effective?
The service was effective.

Staff were suitably trained and supported in their roles. People received effective care and support.

People's rights and liberties were protected in accordance with relevant legislation.

People received a varied and nutritious diet together with appropriate support to eat and drink. They were also supported to access healthcare when required.

Good

Is the service caring?
The service was caring.

Staff treated people with kindness and compassion. They knew the people they cared for well and built positive relationships.

People's privacy was protected at all times and they were involved in decisions about their care, treatment and support.

Good

Is the service responsive?
The service was responsive.

People received personalised care. Staff knew how to meet their nursing needs, including the needs of people living with dementia. Care plans were comprehensive and provided appropriate guidance to staff.

A range of activities was provided which met people's needs and interests. Feedback from people was sought and acted on.

Good

Is the service well-led?
The service was well-led.

Good

Summary of findings

The provider and registered managers conducted a range of audits to assess, monitor and improve the quality of service. They had access to appropriate support to make sure nursing practices remained up to date.

Staff understood their roles, were happy in their work and worked well as a team. There was an open and transparent culture where the views of staff were valued.

Inglefield Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 and 8 October 2015 and was unannounced. The inspection team consisted of an inspector and a specialist advisor in adult social care.

Before the inspection, we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with nine people living at the home and three friends or family members. We also spoke with a senior representative of the provider, one of the registered managers, the deputy manager, 11 care staff, two members of kitchen staff and a housekeeper. We looked at care plans and associated records for eight people and records relating to the management of the service. These included staff duty records, staff recruitment files, records of complaints, accidents and incidents, and quality assurance records.

We observed care and support being delivered in communal areas. 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.

The home was last inspected on 31 January 2014, when we did not identify any concerns.

Requires improvement

Is the service safe?

Our findings

People were not always protected from the risk of infection. Heavily soiled linen was placed into soluble bags, which could be placed directly into washing machines without having to be opened. However, we found these, including one bag that had not been sealed, were sometimes placed in laundry bins with other clothing, which presented a risk of cross contamination. The laundry room could not be locked, which meant soiled clothing and linen were accessible to people, including those living with dementia who might not appreciate the risks.

Laundry and cleaning staff had not received training in infection control, which meant they may not have been aware of current guidance. Cleaning staff were guided by cleaning schedules detailing the method and frequency of cleaning for each area of the home. However, they were not completing the relevant cleaning check sheets, so the provider was not able to confirm that cleaning had been completed in accordance with the schedule. Waste bins in communal bathrooms and sluice rooms included some that did not have lids and some with swing-top lids. These did not meet best practice guidance issued by the Department of Health, which recommends that bin lids are pedal-operated to reduce the spread of infection.

Suitable arrangements were in place for the obtaining, handling, safe keeping and disposal of medicines. However, medication administration records (MAR) showed that the recording of medicines was not always accurate. The number of medicines in stock for two people did not tally with their MAR chart, which showed each person may not have received one of their medicines. MAR charts used to record the use of topical creams used body charts to show where each cream should be applied. However, the records had not been completed fully by some staff, so the provider was unable to confirm that all creams and ointments had been applied as prescribed. Staff monitored the temperature of the fridge used to store medicines that needed to be kept cool, but had not picked up that the temperature had apparently exceeded safe limits on occasions. We drew this to the attention of staff, who investigated and found the thermometer was faulty. This was replaced immediately.

Action had not been taken to reduce some of the risks posed by the environment. People using the garden had access to a flight of concrete steps in one area which posed a risk to those with reduced levels of mobility. A ramp connecting a first floor lounge with an adjacent corridor was very steep. Staff took steps to reduce this risk, for example by bringing people using wheelchairs down the slope backwards and the ramp was covered with non-slip rubber. However, the steepness of the ramp presented a falls risk to people who mobilised independently. One of the registered managers told us building work was planned to this area of the home, which would include removal of the ramp in the near future. Some corridors were cluttered with equipment, such as hoists, whose batteries were being charged from power sockets on the walls. These and the cables connecting them presented a potential trip hazard. During the inspection, staff took steps to tidy these areas and reduce the risk. Fire exit doors were alarmed so staff would be aware if people opened them, although one alarm had become detached, so was not operating correctly. Cleaning trolleys, containing products that may be harmful if swallowed, were left unattended in corridors for brief periods. These were accessible and posed a risk to people, including some who were living with dementia and may not have been able to recognise the products as harmful.

People had access to fall saving equipment. Where people sometimes forgot to use their walking aids, alarm mats were put in place to alert staff when the person moved to a potentially unsafe position. However, at one point during the inspection we saw an alarm mat had not been put in place for a person who had been assessed as needing it. The person mobilised independently, without support from staff, which put them at risk.

The failure to ensure people were protected from the risk of infection, the safe management of medicines, risks posed by the environment and the risk of falling was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other aspects of infection control were safe and appropriate. Most of the above issues had been identified by a recent audit and were in the process of being rectified. For example, all staff had been given infection control workbooks to complete to make sure their knowledge was up to date. They had access to personal protective equipment, such as disposable gloves and aprons; these were accessible in key places throughout the home and we observed staff using them appropriately. Infection risks to people who used catheters or who received food via a PEG

Requires improvement

Is the service safe?

(Percutaneous endoscopic gastronomy) were managed effectively; clear guidance was available for staff and records confirmed best practice guidance was followed. A PEG is used for people who are unable to receive nutrition orally and are fed through a tube directly into the stomach through the abdominal wall.

Other risks to people were managed effectively. For example, equipment such as bath hoists, lifts and stand aids was checked and serviced regularly and portable electrical equipment had been tested by a suitably qualified person. Windows of upper floor rooms had appropriate restrictors fitted so people could not fall through them. Where people had been assessed as needing bed rails to keep them safe, and these were in their best interests, we saw they were being used. Staff showed they understood people's individual risks; they assessed, monitored and reviewed these regularly and people were supported in accordance with their risk management plans. People who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. The pressure relief mattresses were set appropriately, according to the person's weight. One person said, "I've had no aches and pains since I had this mattress; it's wonderful." Where people needed to be turned to reduce the risk of pressure injury, their care records confirmed this was done regularly. Where people were at risk of choking on their food, they had been referred to specialists for advice and placed on suitable diets to reduce the risk. A person who was at risk of high blood pressure caused by an unusual condition had their blood pressure checked daily and staff were clear about the action they needed to take if the person's blood pressure was raised to a dangerous level.

When staff used hoists and stand-aids, they did so in pairs and in accordance with best practice guidance and the training they had received. Where people had experienced falls, senior staff reviewed the risks and took appropriate action to reduce the likelihood of further falls. A system was also in place to capture details of all accidents and incidents in the home, so any patterns could be identified and action taken to reduce the level of risk.

People told us they felt safe at the home. One person told us "I feel I'm in a very safe place." A family member said, "I don't worry about [my relative] at all. I know they're in safe hands and are well looked after." Another family member told us "I feel secure because [staff] are always open and willing to talk about things." Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse. The provider followed local safeguarding processes and responded appropriately to any allegation of abuse. Staff were encouraged to raise concerns with the registered managers, or senior representatives of the provider, and were confident appropriate action would be taken.

There were plans in place to deal with foreseeable emergencies. The home had a defibrillator which the nurses had been trained to use. All staff had undertaken first aid and fire awareness training. They were aware of the action they should take in emergency situations. Personal evacuation plans were available for all people. These included details of the support each person would need if they had to be evacuated. Staff put these plans into action during the recent activation of a fire alarm. The plans were found to be effective and staff managed to evacuate people from the affected area before the fire service arrived.

There were sufficient staff deployed to meet people's needs at all times. One person told us "You've only got to press the bell and you get help." Another person said, "Staff come quickly when I call them." The process used to recruit staff was safe and helped ensure staff were suitable to work with the people they supported. Appropriate checks, including references and Disclosure and Barring Service (DBS) checks were completed for all staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff confirmed this process was followed before they started working at the home.

Good

Is the service effective?

Our findings

People received effective care from staff who were suitably trained. One person told us "They look after me very well." A family member said, "Staff know what they're doing; they're very good."

Staff had completed a wide range of training relevant to their roles and responsibilities. Arrangements were in place to make sure nurses met the needs of their continued professional development through the use of shared learning, discussion and by attending appropriate training courses. Care staff praised the range and quality of the training and told us they were supported to complete any additional training they requested. A recent review of staffing by one of the registered managers had identified that training for some staff was overdue and we saw training dates had been set for this.

A high proportion of staff had completed, or were undertaking, vocational qualifications in health and social care. One staff member told us "I get all the training I need. If I needed anything else I could ask for it and I know [the registered manager] would arrange it." We observed that the training had been effective. For example, staff were skilled at communicating with people living with dementia. They made eye contact with people, spoke clearly, used simple language when necessary and gave people time to respond.

New staff worked alongside experienced staff until they had been assessed as competent to work unsupervised. They also undertook a comprehensive 12 week induction programme, which included completion of the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care.

Staff told us they were supported appropriately in their role, felt valued and received regular supervisions. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. Most staff who had worked at Inglefield for more than a year received an annual appraisal, although these had not yet been completed for a small proportion of staff who were due one.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. Staff showed an understanding of the legislation; before providing care, they sought consent from people using suitable language which supported the person to understand and make as many decisions as they were able to. Where people had capacity to make certain decisions, these were recorded and signed by the person. Where people had been assessed as lacking capacity, best interest decisions about each element of their care had been made and documented, following consultation with family members and other professionals.

The provider had appropriate policies in place in relation to Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. DoLS authorisations were in place for two people and further applications were being processed by the local authority. Staff were aware of how to support people to keep them safe and protect their rights.

Most people were satisfied with the quality of the food. One person said, "It's lovely and you always get a choice." Another person told us "I'm a fussy eater and they make things especially for me." People were offered varied and nutritious meals appropriate to the seasons, including cooked breakfasts daily. Alternatives were offered if people did not like the menu options of the day. Drinks were available and in reach throughout the day and staff prompted people to drink often. People were encouraged to eat and staff provided appropriate support where needed, for example by offering to help people cut up their food or by supporting people on a one-to-one basis. Special diets, including fortified meals and high calorie supplements were available for people who required them.

People who were being nursed in bed received appropriate support to eat and drink. Drinks were within reach of people who could drink independently. People who needed help to drink were offered drinks at least every hour throughout the day. Records of the amount people ate and drank were maintained and confirmed people had eaten and drunk enough. Where people started to lose weight, prompt action was taken to identify the cause and

Good

Is the service effective?

encourage them to eat more. The staff member who provided regular drinks to people told us "We only use whole milk, except for one person who doesn't like it. Milkshakes are very popular and help build people up."

People were supported to access other healthcare services when needed. Records showed people were seen regularly by doctors, dentists, opticians and chiropodists. One person was receiving support from another care provider who was trained to use a particular piece of equipment. The staff member from this provider told us the arrangement worked well and that staff at Inglefield worked well in partnership with them. The person receiving this care led a busy life, so staff had set up a diary, which had helped the person keep track of their numerous visits and appointments with specialists.

Good

Is the service caring?

Our findings

People were cared for with kindness and compassion. One person said of the staff, "They're very friendly and very kind; they couldn't be nicer." Another person said, "Staff are fine; they treat me well." A family member told us "I'm impressed with the sensitivity shown to residents who need help. Staff are unhurried and caring." Another family member described staff as "always polite, cheerful and helpful".

We observed positive interactions between people and staff. Staff recognised when people needed time or reassurance and stopped what they were doing to provide this. Staff knew people well, used their preferred names and their knowledge of people's lives and backgrounds to strike up meaningful conversations and build relationships. For example, when a person who had recently arrived at the home became distressed, staff took time to explain where the person was and how they would help them. The person responded by saying, "You know all about me, don't you?" During a tea round a staff member said, "I'll give [person's name] some biscuits. I know they'll want some." The person laughed and said, "You're right. You know what I like."

People were encouraged to remain as independent as possible in line with their abilities and were encouraged to make choices. For example, staff asked people where they wished to take their meals, where they wanted their drinks, how they wished to be positioned in chairs and beds and whether they wanted their doors left open or closed. People who were able to mobilise without support were encouraged to do so. People's bedrooms were personalised with photographs, pictures and other possessions of the person's choosing to help make their rooms feel homely.

Staff ensured people's privacy was protected by closing doors when personal care was being delivered. They also hung signs on the doors of bathrooms and people's rooms to make sure people were not disturbed while receiving personal care. One person told us they were treated with "dignity and utmost care" at these times. Staff explained how they took time to ask what help the person wanted, made sure the person was at least partially clothed at all times and explained each step of the process. A relative said of the staff, "They always make sure they have [the person's] attention before they carry out tasks. They are respectful and gentle, yet purposeful in their approach." We observed staff adopting this approach when using equipment, such as hoists, to support people to move. People were given a choice of receiving support from male or female staff. Their choices were recorded and respected; there was a good mix of male and female staff available to meet people's individual preference.

When people moved to the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the nursing care, treatment and support they needed. Comments in care plans showed this process was on-going and family members were kept up to date with any changes to their relative's needs. A family member said, "The whole procedure was very easy and [the person] is now getting the care they need." When decisions were made by doctors about resuscitation, records showed relatives, or the people themselves if they had capacity, had been informed and involved in discussions about this.

Good

Is the service responsive?

Our findings

People received personalised care from staff who understood and met their needs well. One person said, "I get all the help I need at the time I need it." Another person told us, "Everything [staff] do for me suits me very nicely." A family member said, "They treat [my relative] as an individual. I've never had cause for complaint."

Care plans provided comprehensive information about how people wished to receive care and support. For example, they gave detailed instructions about how each person liked to receive personal care, how they liked to dress and where they preferred to spend their day. The care plan for a person with an unusual and complex condition contained clear advice and guidance for staff and identified all aspects of the person's care that could trigger an adverse reaction. Staff understood the person and their condition well and were able to explain how they met their needs effectively.

Staff were flexible and supported people at the times they preferred. For example, one person told us they chose to have baths early in the morning. They said, "It suits me as I feel tired at night, and [staff] are happy to do it." A staff member told us "You have to be flexible as [people's] needs change all the time." Monitoring records for people who were being nursed in bed showed they received appropriate care. Charts detailing when they were supported to reposition, were supported with their continence or personal care, or were given food and drink were all up to date.

The home had taken part in an initiative designed to enhance the care people received at the end of their lives. This had involved working closely with other professionals to help identify when people were approaching this stage and preparing them and their family members for this time. Due to circumstances beyond the control of the home, the initiative had been put on hold. However, staff continued to use key elements from the initiative. These included working with palliative care specialists to assess the stage each person was at and creating a calming, peaceful environment for the person.

People were encouraged to take part in a range of activities designed to meet their individual needs and interests. These were recorded in people's care plans, together with information about how staff could prevent people from becoming socially isolated. People who preferred to stay in their rooms told us staff visited them often and helped them engage in one to one activities, such as reading and craft work which they enjoyed. A recent activity involved people each painting a square of fabric; the squares were then stitched together and made into a large wall hanging that we saw displayed at the top of the stairs. People made positive comments about this and staff told us they were planning to take the wall hanging into the rooms of people who were being nursed in bed, so they could see and enjoy the results of their handiwork.

Staff understood the needs of people living with dementia who had difficulty expressing themselves verbally. For example, information in one person's care plan indicated they may need to visit the bathroom when they behaved in a certain way. We observed the person doing this and saw a staff member respond promptly by offering to take the person to the bathroom. Where people's illness caused them to behave in a way that put themselves or others at risk, monitoring charts were used to identify possible triggers and the type of support that was most effective for each person. These helped improve staff responses and reduced the level of anxiety for people.

Staff followed best practice guidance relating to the care of people with diabetes. People were routinely screened for diabetes on admission and at three monthly intervals thereafter. One of the registered managers told us this had helped identify people who had not been diagnosed as having diabetes previously. Guidance was available to help staff identify when people were experiencing sugar levels above or below a safe limit, together with emergency medicine to treat people. Nursing staff and kitchen staff showed a good understanding of diets suitable to people with diabetes and made sure these were always provided.

The provider sought regular feedback from people using questionnaire surveys. A family member said, "They ask my views from time to time. If I ever had any concerns I'd go to [a senior member of staff] and I know they would deal with it." A family member who had raised concerns told us their concerns were "acted on appropriately". Following comments made in the last survey, action had been taken to reduce the incidence of clothing going missing and increase the visibility of management by arranging for people and relatives to meet with senior staff more often. One of the registered managers had interpreted a lack of response from people about activities as something they

Good

Is the service responsive?

needed to look at more closely. As a result, activity staff had been asked to spend time talking to people on a one-to-one basis about this. Their comments had subsequently been used to change the type of activities offered. The menu had also been changed in order to suit people's preferences.

There was an appropriate complaints policy in place, which people and relatives were aware of. Records showed complaints had been dealt with promptly and investigated in accordance with the provider's policy. The findings of investigations were documented and the outcomes shared with the complainants.

Good

Is the service well-led?

Our findings

People liked living at the home and felt it was well-led. One person said, "The home is well-run; everything is very organised." A family member told us "I'd recommend the place to others." Comments from family members to a recent survey by the provider included: "There's a good sense of teamwork among the staff"; and "Management are to be congratulated on running a nursing home with competent and committed staff".

Audits of all aspects of the service, including care planning, medicines, infection control and the environment were conducted regularly and were mostly effective. Where improvements were needed, action plans were developed and changes made; these were then monitored to ensure they were completed promptly. For example, the environmental audit had identified the need for some bed rail bumpers to be replaced and we saw these were on order; an appropriate action plan was in place and being followed to address the concerns we identified in relation to infection control. A senior representative of the provider conducted monthly visits to the home to support the registered manager and monitor the implementation of any improvement actions. As part of this process, they had recently evaluated the effectiveness of staff training and, as a result, had split one course into two to make sure staff gained maximum benefit from their training.

There was a clear management structure in place, all staff understood their roles and worked well as a team. They praised the management who they described as "approachable" and said they were encouraged to raise any issues or concerns. One member of staff told us "We're like a family, we all pull together." Another staff member said, "I'm happy here. The place is well-run, the manager's approachable and everyone knows what they are doing." Another told us "I'm happy here, there's a good team." The provider made good use of 'support nurses' to bridge the gap between care staff and trained nurses. The support nurses had additional qualifications and responsibilities and worked under the supervision of registered nurses. This freed up time for nurses to focus on aspects of care that only they were qualified to deliver.

The registered managers, who were trained nurses, acted as the clinical leads. They had access to advice and support from the provider and trade bodies which circulated information about current nursing care practices. One of them had advanced management qualifications and the other was being supported to gain them. They said, "What's good is that there's always someone at the end of a phone [to provide advice]." They also attended 'matrons meetings', a forum for nursing home managers, to which guest speakers were often invited, to discuss issues of common interest and updates on best practice in nursing care.

There was an open and transparent culture within the home. Visitors were welcomed, the provider notified CQC of all significant events and there were good working relationships with external professionals. One healthcare specialist told us "This is a good home and staff are always cooperative. It runs well." The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or CQC if they felt it was necessary.

Staff meetings were held regularly to update staff on developments and seek their views about the service. The views of staff were also sought as part of the supervision and appraisal process and the provider used this feedback to help drive improvement. Staff described staff meetings as "really good". One staff member told us "You feel free to say anything you want and you are listened to. Things do change and good ideas are acted on. If not, [the management] always explain why." A suggestion box was used by staff to provide feedback or request agenda items for the next staff meeting. A staff member said "You can use the box and make comments anonymously if you want. They are always read out and taken seriously." We found improvements had been made following such suggestions, including the introduction of milk shakes with the drinks round and an extension to the early shift to enable staff to support people's continence better.

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 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way in relation to aspects of infection control, the management of medicines, and the health and safety of service users. Regulation 12(1) & 12(2)(a)(b)(g) & (h)