Care Quality Commission

Methodist Homes
Willowcroft
Inspection report

Nottingham Road
Spondon
Derby
DE21 7NN
Tel: 01332 676010
Website: www.mha.org.uk

Date of inspection visit: 19 & 21 January 2015
Date of publication: 21/05/2015

Ratings

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

Overall summary

This inspection took place on 19 January 2015 and was unannounced.

Willowcroft is a care home without nursing for up to 60 older people. There are four wings over two floors; each floor has a dementia care and residential care wing. At the time of this inspection there were 56 people using the service, some of whom are living with dementia. The service is located in Spondon in Derby which has amenities and good transport links.

A registered manager was in post, however this person was currently on leave and the position was being covered by an acting manager. 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.

At our last inspection on 16 November 2013, we asked the provider to take action to make improvements. This was because some care records we looked at were not always kept up to date to ensure people's needs were being met.

Summary of findings

Improvements were needed in the storage of care records so that people's personal information was kept securely. We found that not all of the people at the service had personal emergency evacuation plans (PEEP's) in place. The provider sent us an action plan outlining how they would make improvements. At this inspection we saw that the provider had made improvements in these areas.

People who self-medicated were not always protected against the risks associated with poor medicines management.

Some people using the service and staff felt that the current staffing levels did not ensure that there were sufficient staff available to meet people's individual needs.

Risks to people's nutrition was not effective. People were not always supported to maintain their hydration and nutrition. People using the service told us they felt safe and were happy living at the home. The acting manager and staff understood their responsibilities to protect people from harm.

Arrangements were in place to assess and monitor the quality of the service. However further improvement was needed to ensure these systems were effective.

Risk assessments were in place to ensure measures were in place to minimise the identified risks. Staff had a good understanding of people's needs and abilities because they were involved in handover meetings.

Recruitment procedures ensured suitable staff were employed to work with people who used the service.

Staff received health and safety training which related to the needs of the people receiving support. Staff were supported through regular supervision.

People told us they liked the staff and were supported by staff to make their own decisions about their care and support. Our observations showed that staff offered people a choice in how they spent their day.

People told us they saw the GP, dentists and opticians when they needed to.

People told us they enjoyed using the service and received the right support. Relatives we spoke with told us that staff were caring and reliable. People were supported to take part in activities which suited their interest and hobbies**.**

There was a complaints procedure and we saw that complaints had been managed appropriately.

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

Requires improvement

The service was not consistently safe.

Policies in relation to medication management were not followed. This meant that people were not always protected against the risks associated with poor medicines management.

The current staffing levels did not always ensure that peoples' needs would be met in a timely manner.

People using the service and their relatives felt safe. Staff knew the procedure to follow if they were told about any abuse happening or had any suspicions of abuse.

Recruitment procedures ensured that suitable people were employed.

Is the service effective?

Requires improvement

The service was not consistently effective.

People who lacked capacity were protected under the Mental Capacity Act 2005 and Deprivation of Liberty safeguards.

Staff had received appropriate training to ensure that they could support people.

People were not always supported to maintain their hydration and nutrition.

People were usually referred to the relevant health care professionals when required, which promoted their health and wellbeing.

Is the service caring?

Good

The service was caring.

People using the service and their relatives told us they liked the service and the way staff cared for people.

We saw that people were treated with kindness and compassion when we observed staff interacting with people using the service.

People's privacy, dignity and independence was promoted.

People were involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People using the service lead active social lives that took into account their individual needs.

Summary of findings

People knew how to make complaints. Complaints records showed that complaints were responded to and addressed appropriately.

Is the service well-led?

Requires improvement

The service was well-led.

People using the service, visitors and staff we spoke with were positive about the management at the service.

Some improvements were needed in relation to the quality assurance systems.

Staff told us that they felt supported by the manager and how they worked well together.

Willowcroft

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 19 and 21 January 2015 and was unannounced.

On the first day of the inspection, the team consisted of two Inspectors and one 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. On day two of the inspection, there was one Inspector.

Before the inspection, we asked the provider to complete a provider information return. This 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.

Prior to our inspection, we reviewed the information we held about the service, which included notifications. Notifications are changes, events or incidents that the registered provider must inform CQC about. We contacted the local authority's contract monitoring team and asked them for their views about the service.

We used the short observational framework tool (SOFI) to help us to assess if people's needs were appropriately met and they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 13 people using the service, six relatives and one visiting professional regarding their experience of the service provided. We also spoke with the acting manager who was managing the day to day running of the service, the deputy service manager, 12 care staff and two domestic staff. We also spoke with a Reverend and a music therapist who were also employed by the provider.

We looked at six people's care records, medication administration records for two of these people, four staff recruitment records and a sample of training records. We viewed other records which related to the management of the service including the quality assurance systems, policies and procedures.

Requires improvement

Is the service safe?

Our findings

At the last inspection on 16 November 2013, we found that effective procedures were not in place for dealing with emergencies and that people's care plans were not being followed which placed them at risk. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan outlining how they would make improvements.

At this inspection the management team told us that all the people living at the home now had personal emergency evacuation plans (PEEP's) in place. For example two of the care records we looked at contained PEEP's. The deputy manager told us that these were reviewed annually and updated if there have been any changes. We saw that people were receiving care in accordance with their support plans, to ensure they were safe For example, staff confirmed the level of support people required which was reflective of their care records.

We checked the service's arrangements for managing people's medicines. A locked fridge located in the same room stored medicines requiring refrigerated storage. The temperatures were recorded daily; however the current month's recorded temperatures ranged between -2 to -8C and the two previous months had recorded temperatures of -10C. This did not reflect the provider's policy that stated the fridge temperatures should be maintained between 2 – 8 degrees. There was no explanation as to why the temperatures were not within the recommended range. This did not ensure that medicines requiring cool storage were being stored at the correct temperature range so that they were fit for use.

We saw that two people self- administered their own medicines. Both had risk assessments in place that had been regularly reviewed. A senior care worker told us that each person had a lockable drawer to store medicines safely. Medicines for the month were supplied to each person. We were told by the senior staff member that "There are no checks during the month of each person's medication." However we were told by management that medicines should we checked weekly.

The provider did not have robust procedures in place to monitor people who self-administered their medication. The provider's medication policy regarding people that self-medicated stated that "Residents medicines are to be checked regularly (this should not exceed 7 days)." We looked at the medication administration records (MAR) of the two people who self-administered their own medicines. We found that weekly checks were not being taken in relation to these two people, which was not in line with the providers own policy Staff told us that any medication surplus at the end of the cycle would be returned to the pharmacy. The returned-medication book showed no tablets had been returned over the previous two months for either person. There was a monthly check of the medication risk assessment but no record of a count of medication or even a visual check of medicines. This showed that medications was not managed appropriately to ensure people were kept safe.

This was a breach of Regulation 13 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our observations showed that staff administered medicines safely. Records were kept of medicines received into the home and when they were administered to people. There were no gaps on the administration records and any reasons for people not having their medicines were recorded. There were clear protocols for 'as required' medication and correct codes were used to show when these had been administered.

A number of the people who used the service and some people's relatives we spoke with felt that staffing levels were not always adequate. They told us that staff were not always available at the times they needed them. One person using the service told us "There are odd days when they seem to be short staffed but, they all work very hard." One relative said "On the whole staff were excellent but [Person's name] had to wait longer then they felt was acceptable. One person said that this was a particular problem after 8pm and that on one occasion they had been told by a member of staff "There are only four of us [staff] to look after you all."

Most of the staff we spoke with told us that the staffing levels were not always adequate and felt more staff were needed. Staff expressed that on the dementia unit three staff members were needed, in particular in the mornings when supporting people with personal care. A staff member told us the main difficulty was when people

Requires improvement

Is the service safe?

needed personal care supported by two members of staff for example when a person required hoisting. This left only one staff member covering the lounge and or the unit. Comments included "We could do with more staff, as it's very busy in the mornings. We don't always have a floater [Staff member working between units], due to staff sickness or if they are on holiday," When there are three carers working there are no problems and "We are getting more people with higher dependency levels."

Staff we spoke with also raised concerns about staffing levels on the night shifts. Staff told us "At night we are short staffed as there is a vacancy. There is also high staff turnover at night due to managing one unit which could have up to 16 people. Once we are fully staffed we will be fine". Another member of staff told us "Staffing levels at night are not good." This demonstrated that staffing levels did not always ensure that people's needs were met.

This was a breach of Regulation 22 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2010, which corresponds with Regulation 18(1) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

People who used the service and their relatives told us they felt safe with the care and support provided at Willowcroft. One person told us, "Safe is a good word for it, it gives me confidence to know that there is help available when I need it." Another person stated "I don't regret moving here, I always feel safe." A relative of a person living at the service said "I now have peace of mind that my family member is safe and being cared for, they could always use a few more staff but I feel happy with how my family member is looked after."

In the interactions we observed between staff and people using the service, we saw that the staff were mindful of people's safety. For example we saw a member of staff moving furniture out of the way of a person who was coming into the lounge using a walking aid.

Notifications that we had received showed that the manager reported alleged incidents of abuse to the local authority to investigate. When the allegations had involved members of staff, the provider took the appropriate action to ensure that people who used the service were protected from the risk of further abuse. Staff told us they had received training in safeguarding people and were able to tell us of the procedures they would follow if there was an allegation of abuse or if they suspected that abuse was happening. This demonstrated that the care staff we spoke with knew and understood their responsibilities in keeping people safe and protecting them from harm. However two of the staff we spoke with were not aware of external agencies they would escalate concerns to if they felt the service had not taken the allegations seriously.

We found people had risk assessments in place that covered risks specific to them, for example regarding falls, pressure sore prevention and nutrition. Risk assessments were up to date and included specific measures for staff to follow.

We looked at four staff recruitment files and saw that checks to assess people's fitness to work at the home had been made prior to appointing the person. This showed that the provider had satisfactory systems in place to ensure suitable people were employed at the service.

Requires improvement

Is the service effective?

Our findings

Care records we looked at contained Malnutrition Universal Screening Tool' (MUST) assessments for each person. People assessed as at risk of poor nutrition and dehydration had a food and fluid chart to monitor their daily intake. We looked at these records for four people. One person's weight chart showed that they had lost weight over a period of time; the GP had been contacted and prescribed food supplements which had been given. For this person and another person the food and fluid chart showed that despite having been assessed as being at risk of malnutrition and dehydration, records for both these people showed that throughout the night no drinks had been recorded. This meant that these people were at risk of dehydration as they may have been without fluids for up to 16 hours.

There was no evidence that people who were at risk of malnutrition were being weighed at the frequency determined on their assessment. This demonstrated that the provider did not have effective systems in place to ensure that people who were at risk of poor nutrition were supported to receive adequate nutrition and hydration.

This was a breach of Regulation 14 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

People using the service and some relatives we spoke to told us they were happy with the care the staff delivered and were confident that staff knew and understood their needs.

Staff we spoke to all told us that they had received adequate training and felt competent to provide care to meet the needs of the people using the service They also told us that the training provided had been relevant to their roles and that they received regular refresher training, to ensure their knowledge was up to date. One member of staff said "I have had dementia training, moving and handling and first aid training. Another member of staff told us "The training is very good."

Staff told us that they had an induction period when they first started working at the home. This involved completing essential training relevant to their roles and 'shadowing' of more experienced staff.

We reviewed how the provider obtained consent from people regarding the care and treatment that was provided to them. The Mental Capacity Act 2005 (MCA) is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. Staff we spoke with confirmed that they had received training on the MCA, and showed a basic awareness of the MCA principles. The service had undertaken assessments of people's capacity in relation to specific decisions such as personal care and people's health and welfare.

A relative had signed a care plan on behalf of their family member who did not have capacity. In one record we saw a form 'Resident and/or relative agreement to contents of care plan' stating they had been involved in the preparation of the plan and had read and agreed with the content. Another relative told us that she had helped to develop her family members care plan when they first came in and that she was regularly asked about it and informed if there were any changes.

Our observation showed that staff routinely involved people in decision making throughout the day and asked for their consent when they required support.

The acting manager told us there were two people living at Willowcroft who were currently subject to a Deprivation of Liberty Safeguards (DoLS). This is a law that requires assessment and authorisation if a person lacks capacity and needs to have their freedom restricted to keep them safe. A further DoLS application had been submitted to the local authority and the service were awaiting a decision. Staff we spoke with had an awareness of DoLS. The provider had taken steps to ensure us that people were not subjected to restrictions which may be unlawfully placed on them.

People using the service and some relatives we spoke with told us staff made appropriate referrals and involved other healthcare professionals in their care and support. One person told us they had good access to GPs and was waiting to be seen by the GP during the inspection visit. A relative told us, they raised their concerns with the deputy manager about the change in medication for their family member. The deputy manager supported them and arranged a GP visit. The relative said that they could

Requires improvement

Is the service effective?

express their views to the service, they were "listened to and action was taken". Another relative said "We are always called if there has been a problem with my family member's health. "

A visiting community nurse told us that they were always contacted if help or advice was needed from them by the home.

We observed that staff showed concern for people's wellbeing in an effective and caring manner and responded to their needs. For example we saw that on the Nightingale wing a member of care staff became concerned about a person's health and well-being. They immediately alerted another member of staff and repositioned this person to improve their breathing. Staff contacted the GP, followed by a call to the ambulance service.

People's health care needs were well documented in care records. Diagnosed conditions were recorded and staff we spoke with were aware of those conditions and actions needed to maintain good health. We saw in people's care records that referrals had been made to a range of health care professionals and their advice had been included in care records. These included the GP, district nurse, dietician and community psychiatric nurse (CPN). A medical history report had been provided by the GP and included in care records so that staff were aware of this information whilst providing care.

A member of staff told us that they had recently instigated 'ward rounds' with two GP practices that they worked with. This meant that the practice told them specific days when they would come to the service and review anyone who wanted to see them. Prior to the visit the staff usually went round and checked with people if they wanted to see a doctor. Staff told us if someone needed to see a doctor outside of this they could be called at any time as necessary. During the inspection we observed health care professionals visiting some people at the service, which included GP's and community nurses.

People we spoke with told us they enjoyed the food and the choices offered. One person said "The food is very good." However another person said "The food is ok but monotonous sometimes." People told us they liked the 'light' lunch and enjoyed the evening meal. We observed the support people received during both lunch and tea. People were very relaxed and enjoying the food together. We saw that staff were aware of people's likes and dislikes in relation to food choices Where people required assistance with their meals staff did this in a dignified manner and at an unhurried pace. A visiting relative told us, "The food is excellent. We came for Christmas dinner and all sat together. The food was cooked to perfection. People here can have a drink, biscuits or other snacks at any time; they can have anything they wish."

Good

Is the service caring?

Our findings

People we spoke with told us they enjoyed living at the home and felt that the staff were caring and kind. One person told us "I am registered blind and they [staff] are all very patient with me, there is always someone there to help me." Another person stated "The staff are very kind and they look after us well." Another told us "I would give this place [Willowcroft) five stars, I'm very sincere about that it's like being in a hotel." Relatives of some people living at the service and a visiting professional told us the staff were friendly.

There was a very relaxed atmosphere at the service during our inspection visit. Our observation of people's care over the two days showed that staff were caring and helpful. We saw care staff approach people using the service with respect and in a kind and compassionate way. We observed care staff sitting with people in the communal areas. They interacted well with people whilst engaging in conversations with them. This demonstrated that people were treated in a respectful manner and received individualised care.

Our observations showed that staff were caring and understanding. People who became distressed due to their conditions were given reassurance and support by care staff. Care staff were able to divert people who became upset. For example, a person who could not find their bedroom and repeated the same question became agitated. A staff member said, "[Person's name] I will take you to your room but I bet you would like a really nice cup of tea with me first. Why don't we go into the kitchen to get one together." This had a positive effect on the person as they became settled as they engaged with the staff member.

We observed people who were being assisted to move with the use of a hoist, and saw that their dignity was promoted whilst being transferred. For example we saw staff covering people with blankets ensuring their modesty was maintained.

People living at the service told us that staff were welcoming of their visitors; so that people were supported to maintain relationships important to them Relatives we spoke with also confirmed this.

Some people who used the service lacked the capacity to make decisions for themselves. The acting manager told us that advocacy services were available to support people in the decision making process. Also, family members and other representatives were involved in decision making if necessary. This meant that the people were being supported in making decisions about their care when they required support to do so.

Care staff we spoke with told us they encouraged people to maintain their independence as long as they were safe to do so. One member of care staff told us, "We try and let people be as independent as possible, we recognise when they may need support." Another member of care staff stated "People are given choices and supported to maintain their independence." Throughout our visit, we saw staff encouraging people to make their own decisions and move around independently. This meant people's independence was promoted.

Good

Is the service responsive?

Our findings

People told us that they enjoyed their lifestyles at Willowcroft. One person told us "I love the 'knit and natter' sessions because we all have a good chat and when we play skittles on the corridor on Tuesday it's good fun." Another person said "I have no complaints it's excellent here, you can spend your time as you please. We have coffee mornings, religious service, play board games and I tend to go out with my family." A visiting relative told us, "The home is very responsive to suggestions. We asked if our relative could sit at a table in the dining room with people he was able to talk with. Some people are unable to communicate. This was simply arranged. Staff are so loving towards people, providing them with reassurance."

A number of people and their relatives told us what a good time they had had Christmas. They told us that staff had arranged for long tables placed down the corridor and decorated so that they could have Christmas lunch together.

People using the service told us that a Reverend came to the home and religious services were held every week which they welcomed. They also told us that they could speak to them outside of the services and that they could talk to them about anything. Staff told us that a weekly quiz morning and regular singsongs took place; this was confirmed by the people we spoke with. We spoke with the music therapist who visited the service once a week. This person also carried out one to one sessions with people living with dementia. We observed a group music activity taking place which the people using the service participated in alongside some staff. We observed a variety of activities taking place, such as a scrabble game a person told us, "We all help each other with this game, it is good." Reminiscence sessions were undertaken to encourage people to discuss the past and issues of interest together. This showed that people were able to participate in activities which interested them.

A relative who visited several times each week told us, "We can come at any time. We play games with the people here and help to wash up, like part of a family. There is a religious service here each Wednesday. People really enjoy that. They have a music therapist who visits each week and sees people individually. My relative used to play the piano by ear. The therapist has encouraged him to play, the interaction is good. There is a lot going on here. They have internal coffee mornings, play skittles and other games".

Our observations throughout the inspection showed that relationships between the people using the service and staff were positive. We saw staff interacting with people, asking them about their likes and dislikes in order to provide care and support in the ways that people preferred. People we spoke with told us that they were able to spend their time as they wished, they could use the communal areas and if they preferred stay in their rooms.

People's care records showed that their needs were assessed prior to admission to the service; these showed that people and their relatives had been involved in the process.

People were involved in deciding what care they needed some people were unable to recall if they were involved in the written care plans. Two relatives told us that they had been involved in care planning and were asked to review plans regularly. A member of staff told us that they sat with a person who recently joined the service and discussed with them their social history and their choices and preferences in the care they were to receive.

We saw that staff were responsive to people's individual needs. For example, a member of staff approached a person sitting in the lounge. The member of staff told us that the person usually joined in with a game of scrabble so he thought he should check if the person was ok. The person told him that they didn't feel very well. The member of staff said they would observe the person and share this with senior care worker if necessary. Our observations showed that a person who was living with dementia went out into the garden area without a coat. A member of staff went outside to the person and persuaded them to come back in as it was very cold and the person did not wish to wear a coat. The member of staff provided the person with reassurance.

People living at the service we spoke with and some relatives felt the care given was personalised and took into account individual needs.

A relative told us that staff had been helpful in re-locating their family member from another part of England. They were involved, together with their family member in the discussions and arrangements for the transfer. The care

Good

Is the service responsive?

plan had been established with them and their family member said, “They write good records, we are involved and there is an open approach. We have seen the completed care records and they are open for us to read at any time.”

Staff explained how they monitored the condition of people’s skin and the range of preventive measures in place, to reduce the risk of pressure sore development. An airwave mattress and pressure relieving cushion together with regular repositioning were part of prevention for one person. We saw this person sitting on a pressure relieving cushion in the lounge, an airwave mattress was in place and we found that there had been regular re-positioning throughout the 24 hour period. Staff told us that if they noticed a reddened area on a person’s skin it was reported immediately to the district nursing service who responded swiftly and carried out an assessment. This demonstrated the provider had taken steps to ensure people’s individual needs were identified and staff responded to people’s changing care needs.

People using the service and relatives we spoke with told us they knew what to do if they had any concerns. They felt confident that they would be listened to and their concerns would be acted upon. Two people using the service told us that if they were worried about anything they would tell their relatives. Relatives we spoke with told us that they would speak with the manager or care staff if they had concerns.

The provider had systems in place for handling and managing complaints. The complaints records we looked at confirmed that these were investigated and responded to appropriately. Staff we spoke with knew how to respond to complaints if they arose. Information on how to raise concerns was displayed in the home so that people and their relatives could access this information.

Requires improvement

Is the service well-led?

Our findings

At the last inspection on 16 November 2013, we found that records were not always kept in relation to people's care needs and people's care records were not stored securely. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection we saw the provider records were kept in locked cupboards. On day one of the inspection on one of the dementia wings this cupboard was not locked, we raised this with staff and the cupboard was locked immediately. We found that the care records we looked at had been kept under review and updated as required. This demonstrated that accurate records were kept in relation to peoples' care needs and that care records were being kept securely.

We saw that the provider had quality monitoring processes in place. This incorporated monthly medication audits, care plan audits and infection control. Accidents, incidents and falls were analysed to identify any patterns. We saw that when a pattern was identified the management team had taken action to minimise the risks of a re-occurrence. For example, where a person had two or more falls the management team were in the process of contacting the NHS 'falls team'. This was in order to obtain specialist advice about how to reduce the risk of these people falling. However we noted that further improvement of this system was needed. For example in relation to the management of medicines.

People we spoke with told us they were asked their opinion of the service and most told us they were confident they would be listened to. The provider's quality assurance system included an annual survey of people using the service and their relatives so that improvements could be made to the service provided. 'Residents meetings' were also held regularly. We found the provider's vision and values were expressed in the new residents guide which were given to people when they moved to the service.

People using the service and relatives we spoke with were positive with regards to the management of the service.

One relative shared some concerns with staff. They said "The carer informed the deputy manager straight away and the problem had been resolved". Another relative told us that the deputy manager was excellent and could always answer any queries they had or explained things to her if she needed information. They also told us that they felt if they did want to make any complaints they would speak to the deputy manager and that they felt confident that they would be handled well.

There was a registered manager in post, however at the time of the inspection they were on leave. An acting manager was in place to manage the home on a day to day basis. The acting manager's knowledge of the role was developing and they were being supported by the provider in the registered manager's absence.

Staff we spoke with felt it was a good place to work. They told us that the management of the service had improved and they felt supported. One staff member said "The management are helpful" and another said "I feel the service is well run and the acting manager will listen to you."

Staff told us that staff meetings took place, which allowed them to share their views about the service.

The provider had a whistle-blowing policy. Staff told us that they felt able to raise any concerns without the fear of any form of repercussion. Comments included "I would go to the manager if I had any concerns" and "I would either speak with the senior care staff or the acting manager if I wanted to raise something." This provided assurance that the provider encouraged an open and supportive culture.

Systems were in place to ensure that the maintenance and servicing of equipment had taken place when required. We saw a sample of health and safety records which showed that the servicing of equipment and building were up to date. This included gas and lift servicing and portable appliances testing. The acting manager told us that there was an onsite maintenance person who was responsible for carrying out maintenance checks. This ensured the provider had arrangements in place to monitor the safety of the premises and equipment.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Policies in relation to medication management were not followed. This meant that people were not always protected against the risks associated with poor medicines management.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: People were not always supported to maintain their hydration and nutrition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The current staffing levels did not always ensure that peoples' needs would be met in a timely manner.

This section is primarily information for the provider

Enforcement actions

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