Wall Hill Care Home Limited

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Inspection report

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Date of inspection visit:
15 February 2017
16 February 2017

Date of publication:
02 May 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 15 and 16 February 2017.

Wall Heath Residential Care Home provides accommodation and personal care for up to 34 older people and for people living with dementia. On the days of our inspection there were 32 people living there.

At our last inspection on 27 April 2015, the provider was in breach of regulations 11, need for consent, 12 safe care and treatment and 14, meeting nutritional and hydration needs. The provider sent us an action plan to tell what measures they would take to comply with these regulations. At this inspection we saw improvements had been made. However, there were areas that needed to be reviewed and improved to ensure people received a safe service.

The home has not had a registered manager for week. An acting manager was in place who told us they had submitted an application to be registered with us. 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.

Since the last inspection improvements had been made to ensure practices safeguarded people from the risk of potential abuse. People told us they felt safe living in the home and there were enough staff to care for them. However, some medication practices were unsafe and placed people at risk of harm.

People were placed at risk of harm because systems and practices exposed them to dangerous cleaning chemicals. Staff did not have access to appropriate lifting equipment which placed people and staff at risk of injury. Accidents were recorded, monitored and action was taken to avoid a reoccurrence.

Since our last inspection staff had a better understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards [DoLS]. However, there are areas that could be improved to ensure practices do not compromise people's human rights. Improvements had been made to ensure people's meal preferences were catered for. People were supported by staff who may not be suitably skilled but they did receive regular one to one [supervision] sessions. People were supported by staff to access relevant healthcare services when needed.

People were at risk of receiving unsafe and an ineffective service because the provider's governance did not assess or monitor the service provided to people. Meetings were carried out to enable people to tell the provider about their experience of living in the home. People were aware of the management team and staff felt supported by the managers to carry out their role.

People received care and support from staff who were caring and compassionate. People's involvement in their care planning ensured their specific needs were met in a way that promoted their privacy and dignity.

People were actively involved in their care assessment and were provided with opportunities to pursue their interests. However, the environment was unsuitable for people living with dementia which may add to their confusion. People were able to maintain contact with people important to them. People felt confident to share their concerns with the managers which were listened to and acted on.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Medication practices were unsafe and placed people at potential risk of harm. Practices did not safeguard people from the exposure of chemicals that could harm them. There were sufficient staff on duty and people were protected from the risk of potential abuse because staff knew how to safeguard them from this.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's human rights may be compromised because staff did not always include the principles of the mental capacity act and the Deprivation of Liberty Safeguards in their care practices. People were cared for by staff who were not suitably trained. People had access to a choice of meals and were able to have drinks when they liked. People were supported by staff to access relevant healthcare services when needed.

Is the service caring?

Good

The service was caring.

People were cared for by staff were caring and who were aware of their care and support needs. People's involvement in their care planning ensured they received a service the way they liked. People's privacy and dignity was respected by staff.

Is the service responsive?

Good

The service was responsive.

People's involvement in their care assessment ensured their specific needs were met. People were supported by staff to pursue their interests. People could be assured their concerns would be listened to and acted on.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People were at risk of receiving an unsafe and ineffective service because the provider's governance was not robust. People were encouraged to have a say in how the home was run and staff felt supported by the managers to carry out their role.

Wall Hill Care Home Limited

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 15 and 16 February 2017 and was unannounced. The inspection team comprised of one inspector.

As part of our inspection we spoke with the local authority to share information they held about the home. We also looked at information we held about the provider to see if we had received any concerns or compliments about the home. We reviewed information of statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan our inspection of the home.

During the inspection we spoke with five people who use the service, two care staff, the deputy manager, the acting manager who was also the registered provider and a consultant who was also one of the registered providers. We observed how staff interacted with people and whether people's needs were being met. We looked at two care plans and a risk assessment, medication administration records and quality audits.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 27 April 2015, the provider was in breach of regulation 12, safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We found managers were unaware of their responsibility of sharing information about abuse with the local authority to protect the individual from the risk of further harm. When people had sustained an accident the risk assessment had not be reviewed or updated to reduce the risk of this happening again.

The provider sent us an action plan to tell us what measures they would take to comply with the regulation. At this inspection we saw some improvements had been made. However, other concerns were identified that placed people at risk of harm and the provider remained in breach of the regulation.

At this inspection people were at risk of harm because medicine practices were unsafe. For example, medicines were not stored appropriately and could be accessed by people who had not been prescribed these treatments. We observed some medicines were stored next to a boiler. The acting manager was unable to demonstrate these medicines were stored at the appropriate temperature as identified on the packaging. This meant people may receive medicines that were unsuitable for use. After the inspection the acting manager informed us that arrangements were in place to ensure the appropriate storage of medicines.

Discussions with staff identified some people had been prescribed 'when required' medicines. These medicines are prescribed to be given only when needed. For example, medicines prescribed for the treatment of pain. One medication administration record [MAR] showed the person had been prescribed a medicine for constipation to be taken when needed. The MAR showed this medicine had been given to the person every day. The GP had not been contacted to review the person's medicine and consideration had not been given to look at their diet or how much they drank. The managers were unable to say whether the person needed this treatment every day. Discussions with staff confirmed they did not have access to a written protocol to support their understanding about how to manage 'when required' medicines. Since our inspection the provider informed us they had contacted the GP's for advice in developing a written protocol. This would help the staff to understand when these medicines need to be administered and at what point medical intervention is required.

We saw a medicine used for the treatment of coughs had been decanted into another medicine bottle with a hand written label on it. When we shared this information with one of the managers they said this was common practice. This practice was unsafe and placed people at risk of receiving a medicine that maybe contaminated or out of date. The acting manager assured us this practice would stop.

We found one cream with the label missing. Some labels were not legible and we saw one tube of cream without a top which meant the cream could have been contaminated. One medicine prescribed for the antifungal treatment had expired. Dressing packs were open which meant they were no longer sterile and unsuitable for use. A person had been prescribed medicine patches for the treatment of pain. Instructions on the package said the patch should be alternated on different parts of the body. The patch should not be

applied to the same part of the body for at least three weeks. We spoke with a staff member who confirmed they were responsible for the management of medicines. They were unable to demonstrate this patch was applied as directed by the pharmaceutical manufacturer's instructions and this placed the person at risk of harm. The acting manager assured us a body map would be put in place to support staff's understanding about where to apply this patch. People told us they received their medicines when they needed them. However, practices placed them at risk of potential harm.

A staff member who was responsible for the management of medicines confirmed they had received a competency assessment. This assessment should review and monitors staff's skills with regards to managing medicines safely. However, the staff member did not recognise the medication practices we observed were unsafe.

This is a breach of Regulation 12, safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of potential harm because practices within the home were unsafe. For example, cleaning chemicals were not securely stored and were accessible to everyone in the home. Should these chemicals be swallowed they would cause harm to the individual. The managers confirmed that no one had been harmed by these chemicals but acknowledged there was a potential risk. The managers said the staff member who was responsible for ensuring these chemicals were securely stored had received Control of Substances Hazardous to Health [COSHH] training that promoted safe practices. However, the skills learnt were not put into practice. We found people had access to the laundry and there were no systems in place to ensure the safe storage of chemicals in this area. We shared these concerns with the acting manager who took immediate action to have a lock fitted to the door.

People were at risk of potential harm when staff supported them with their mobility. Staff told us they did not have a hoist and the provider confirmed this. The staff and managers confirmed that no one required the regular use of a hoist. However, they had been times when people had been found on the floor and were manually lifted by staff. This practice placed people and staff at risk of harm. The acting manager told us consideration would be given in purchasing a hoist.

People told us they felt safe living in the home. One person said, "I feel comfortable and safe living here because the staff look after me." Another person said, "The staff are so nice and that makes me feel safe." We spoke with a different person who told us, "I feel safe here because there is always someone around."

Staff were aware of different forms of abuse and how to recognise this. A staff member said, "You can tell by people's facial expressions and their body language if something is wrong." Another staff member told us, "The change in someone's behaviour and unexplained bruising would raise concerns." All the staff we spoke with said they would share any concerns about abuse or poor care practices with the managers. They were also aware of other agencies they could share their concerns with.

Managers were aware of when to share concerns of abuse with the local authority. A record was maintained of safeguarding referrals made to the local authority. The managers were also able to explain what action had been taken to safeguard people from the risk of further abuse. For example, one person's care and support needs had been reassessed and a suitable placement was obtained for them.

We looked at how accidents were managed. The managers told us that accidents were recorded and we saw this. The recording of accidents enabled the provider to monitor for trends and to take action to avoid it happening again. For example, records identified a person had sustained a number of falls. The deputy

manager said a referral had been made to a physiotherapist to review the person's walking equipment. Records also showed there was a trend of another person falling several times. The deputy manager said this information had been shared with the GP. This was to identify whether falls were due to ill health and if so appropriate measures would be taken. For example, to review the person's prescribed medicines.

We found staff did have some understanding about how to safeguard people from the risk of harm. For example, a staff member told us they always made sure people had access to their walking equipment to reduce the risk of falls. Staff said they had access to risk assessments and we saw these within people's care records. Risk assessments promoted staff's understanding about how to keep people safe. For example, staff told us risk assessments informed them about essential equipment the individual may need to mobilise safely. We saw people using walking equipment as identified within the risk assessment.

People were cared for by sufficient numbers of staff. One person said, "I have a buzzer [call alarm] and staff always come." Another person told us, "I've had a couple of falls and the staff came immediately." We spoke with a staff member who said, "There is always enough staff on duty." We observed staff were always available to assist people when needed.

The provider's recruitment process ensured staff were suitable to work in the home. Staff told us references had been requested before they started to work in the home. They confirmed a Disclosure Barring Service [DBS] check had also been carried out. The DBS helps the provider make safer recruitment decisions to ensure the suitability of people to work in the home.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 27 April 2015, the provider was in breach of regulation 11, need for consent, of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. At this inspection we found that the provider had taken action to comply with this regulation. However, improvements were still needed to ensure people's human rights were promoted.

At this inspection all the people we spoke with confirmed staff always asked for their consent before they assisted them. Discussions with staff confirmed their understanding of the importance of obtaining people's consent regarding all aspects of the individual's care and support needs. A staff member said, "I always ask people for their consent before I assist them with their personal care needs." They told us some people were unable to tell them what they wanted. However, their facial expression often indicated their preference. The deputy manager said, "We always assume people have capacity to make a decision." These practices promoted people's rights to make their own decisions.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At our last inspection best interests decisions had been made on people's behalf. However, the provider was unable to tell us or demonstrate how decisions made on people's behalf were in their best interests. The provider sent us an action plan to tell us what measures they would take to comply with the regulation. At this inspection the provider was unable to tell us when and how decisions were made on people's behalf. This meant decisions made in relation to the individual's care and treatment may not be in their best interests.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards [DoLS]. At our previous inspection the registered manager was unaware of when a DoLS should be applied for. Hence, people's liberty had been unlawfully restricted.

At this inspection we found the managers and staff had a better understanding DoLS. The deputy manager said 90% of people who used the service were living with dementia. We were informed that nine authorised DoLS were in place. These were for people who lacked capacity to make a decision and needed to be closely supervised. The deputy manager said it would be unsafe for these people to leave the home without staff's support and the staff we spoke with were aware of this. A staff member told us about a person living with dementia who lacked capacity to make a decision. They said the person would be at risk if they left the home without support from staff. Staff told us if the person wanted to go out they would be supported by

staff to do so. A DoLS application had been submitted to the local authority to lawfully deprive the person of their liberty. However, the managers were unable to confirm whether a MCA assessment had been carried out before the DoLS application had been submitted. This assessment would clarify the person's level of understanding and whether the DoLS application was appropriate.

At our last inspection the provider was in breach of regulation 14, meeting nutritional and hydration needs, of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We found people's meal preferences were not catered for. At this inspection we found the provider had taken action to comply with this regulation.

People were provided with a choice of meals and were supported by staff to eat and drink sufficient amounts. One person said, "The food is alright and if you dislike it they will give you something else." We found a number of people were vegetarians. We spoke with one person who said, "The vegetarian options have improved immensely and I really enjoy the meals now." We spoke with a member of staff who said, "The food here is lovely, I would eat it."

Staff were aware of suitable meals for the individual with regards to their health condition. A staff member told us about a person who was at risk of choking and to avoid this happening they were provided with soft foods that were easier to chew and swallow. We spoke with the cook who was aware the person required soft foods. People told us they had access to drinks at all times and we saw this. A staff member informed us that a drinks trolley goes around the home at certain times but people can have a drink at any time.

We spoke with two staff members who confirmed any concerns about how much a person ate and drank would be monitored closely. The person would also be weighed to identify any significant weight loss. The care records we looked at contained evidence of people being weighed regularly. Staff said where necessary concerns would be shared with the individual's GP for advice and support.

People were supported by staff who did not have the appropriate skills to care for them. Staff confirmed they had received training. However, this consisted of watching a DVD. Two staff members said there were no systems in place to ensure skills learnt were put into practice or to check their understanding. For example, we observed a person required support to manage their behaviour. Although staff remained calm and reassured the person, staff told us they had not received any training about how to support the person with their behaviour. A staff member said, "I haven't received training but their behaviour doesn't have an impact on others." However, staff did not recognise the impact these behaviours had on the person. We observed the person was agitated and unsettled during the course of the inspection. The lack of training meant staff did not have the required skills to support people appropriately with their behaviours and to promote good mental wellbeing. However, people told us they were happy with the service received and staff knew how to care for them.

We spoke with the acting manager about the quality of staff's training. They confirmed training had been reviewed and they were liaising with local colleges in view of providing more suitable training. This would ensure staff had the appropriate skills to care for people.

People were supported by staff who received regular one to one [supervision] sessions. One staff member said, "Receiving supervision makes me feel more confident in my work." Another staff member told us, "During my supervision I can discuss any concerns I may have and receive feedback on my work performance."

We looked at how the provider supported new staff into their role. All the staff we spoke with confirmed they

received an induction when they started to work at the home. A staff member said during their induction they were provided with information about people's care and support needs. Another staff told us, "I was introduced to people and I was made aware of their care needs." This meant people could be confident that new staff would know how to support them.

People were supported to access relevant healthcare services when needed. One person told us, "The staff call the GP for me if I'm unwell." Another person said, "The GP visits the home when needed and I am able to access the dentist and optician when required." A staff member said people would be supported to attend their medical appointments. However, if they were unable to attend these healthcare services, arrangements would be made for a domiciliary visit. Discussions with staff confirmed where people had specific health conditions; they had access to a specialist nurse. For example, a community psychiatric nurse or a diabetic nurse. A staff member informed us about a person who was living with dementia who had access to the memory clinic. Contact with these services ensured people's health condition was routinely monitored.

Good

Is the service caring?

Our findings

People were cared for by staff who were kind and compassionate. One person told us, "The staff are good and look after me." Another person said, "All the staff are different characters but I get on with them all." A different person said, "The staff are caring and nice and they help me in the morning to get dressed." Throughout the inspection we saw staff take the time to engage with people. They spoke with people at a pace they could understand and showed an interest in what the person was saying to them.

People were encouraged to be involved in planning their care. We spoke with a person who was aware of their care plan. They confirmed they had been actively involved in planning their care and was happy with the support they received. A staff member said, "We sit with people and ask them about their care needs." They told us if people were unable to be involved in planning their care where appropriate their family would participate. Another person told us about their involvement in planning their care. They said, "If I wasn't happy I wouldn't live here." Staff demonstrated a good understanding about people's specific care and support needs. One person told us they like to go to their bedroom after lunch to watch television and staff were aware of this and we saw staff support them to their bedroom after they had eaten.

We looked at how people were supported to maintain their independence. One person said, "The staff like you to be independent but they will always help me if I am struggling." They continued to say, "The staff do try to make my life as happy as possible." Another person said, "I do most things for myself but staff will help me when needed." A staff member said, "I encourage people do as much as they can themselves to promote their independence." They told us, "We ensure people have the appropriate walking equipment so they can mobilise and maintain their independence." We saw people using walking equipment to assist them with their mobility. The provider said people had access to specially adapted crockery, cutlery and beakers to enable to eat and drink independently. We saw people using beakers to enable them to drink independently.

People's right to privacy and dignity was respected by staff. One person said, "The staff do respect my privacy and they always knock on my door before entering." A staff member said, "When I assist people with their continence needs, I ask them if they want to be alone for a while." Another staff member told us, "I always ask people instead of telling them." They told us it was important to always explain to people what they intend to do. People told us staff always talked to them in a respectful manner.

Good

Is the service responsive?

Our findings

People were involved in their care assessment. One person told us they had been actively involved in their pre admission and subsequent assessments. Another person told us they were always involved in their assessment and staff always asked them about any additional support they may require. People's involvement in their assessment ensured they received care and support that reflect their preference.

The deputy manager said approximately 90% of people in residence were living with dementia. However, we found the environment was unsuitable to assist people living with this condition. For example, pattern flooring and furnishings were situated throughout the home. Dementia can impact on a person's vision and patterned furnishings and flooring can appear distorted and add to the person's confusion. The acting manager said they had obtained support and advice from other agencies about providing a dementia friendly environment. They told us action would be taken in the near future to provide a suitable environment for people living with dementia. A dementia friendly environment would assist people to be more familiar with their surroundings and help them find their way around the home.

We looked at what opportunities people had to pursue their interests. One person told us, "We had a Valentines party last night and it was very good." They continued to tell us about outings in the countryside. Another person said, "[Provider] takes me out in the mini bus and we travel around the countryside." A different person told us they enjoyed reading the newspaper and this was made available to them. They told us they liked socialising with others in the home. People told us they were satisfied with the activities provided and looked forward to warmer weathers so they could pursue more outdoor activities. A staff member said people had access to a variety of indoor and outdoor social activities. For example, art classes, external entertainers, trips and access to local facilities within their community. A staff member said people's families also took them out. The provider told us people were taken out on a weekly basis to enable them to access their local community. The provider said they had chats with people about familiar areas where they grew up or worked and would take them for drives around these areas to reminisce.

People were supported to maintain their religious beliefs. A person said, "The Priest visited the home yesterday." They told us, "Staff do respect people's religious beliefs." A staff member informed us about a person who enjoyed going to their place of worship and the person confirmed staff supported to attend their chosen place of worship.

People were able to maintain contact with people important to them. One person told us they enjoyed visits from their family. On the second day of the inspection we saw arrangements had been made for this person to visit their relative. Another person said, "My relative lives nearby and visits me regularly."

People told us they were able to share their concerns with staff and the managers. One person said, "If I have any problems I would talk to the staff or the manager and they would sort it out." Another person told us, "I complained about my food being cold and they soon sorted it out." We spoke with a different person who said, "I complained about my clothes going missing and the provider offered to buy me some new clothes." We saw that complaints had been recorded and showed what action had been taken to resolve

them. This meant people could be confident their concerns would be listened to and acted on.

Requires Improvement

Is the service well-led?

Our findings

People were at risk of receiving unsafe and an ineffective service because the provider's governance failed to assess, monitor and improve the service provided to people. For example, the management of people's prescribed medicines were unsafe and placed them at risk of potential harm.

The provider's governance was ineffective to assess and monitor the quality of staff's training. There were no systems in place to identify staff's understanding and whether they had the skills to meet people's care and support needs.

People's safety was compromised because systems were not in place to assess and monitor the risk posed to them where they had access to harmful cleaning chemicals.

The provider's governance did not monitor practices where best interests decisions were made on people's behalf to ensure they received the appropriate care and treatment. Mental capacity assessment were not always carried out before a Deprivation of Liberty Safeguards [DoLS] application was sent to the local authority to deprive the person of their liberty. This meant the provider was unable to demonstrate the person's level of understanding and whether the DoLS application was appropriate..

This is a breach of Regulation 17, good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had developed an action plan to improve standards within the home. This action plan provided information relating to areas where progress was required. For example, improvements to the environment, fire safety and staff training. The provider had identified specific timescales for improvements to be made. However, this action plan did not identify all the shortfalls we found. This meant the service people received may not be adequate to meet their needs.

The registered manager had recently resigned and an acting manager was in post. The acting manager was also the registered provider. The provider had taken over the limited company in 2016. The provider had taken over the manager's post a week prior to our inspection. They told they had submitted an application to register with the Commission. Discussions with the acting manager identified they did not have any experience working in adult care services. However, they informed us they were undertaking the National Vocational Qualification level 5, Care Management to enhance their skills.

People and staff were aware of who was running the home. One person said, "Since the new providers have taken over they have made a lot of positive changes." They continued to say, "The window in my bedroom was rotten and they soon sorted that out." They told us the provider always took the time and sit with them to find out if they were satisfied with the service they receive. Another person said, "The new providers are very good, they are wonderful." A staff member said, "The management support is brilliant and problems are always sorted out." Another staff member said, "The management team are nice and very approachable." The acting manager said they had aspiration to develop a dementia friendly environment

to promote people's independence. However, this was not identified in their action plan of improvements. They said they wanted to ensure all staff had the skills to care for people living with dementia. This would mean people living with dementia would receive the appropriate care and treatment by skilled staff.

People were able to tell the provider about their experience of living in the home because routine meetings were carried out with them. One person said, "At the last meeting we talked about the service and the meals provided." They said they were very satisfied with the service they received. Another person said, "At these meetings we can share our concerns and the managers do address them." They told us, "I would definitely recommend living here." During a meeting people said they enjoyed going out for meals and would like to do this more often. The provider said arrangements were in place to do this. People had raised concerns about the crockery not always being clean. The provider told us about plans to redesign the kitchen and to install a dishwasher which would resolve the problem.

Staff meetings were carried out frequently. Staff told us the provider listened to them and took their views on board. For example, during a meeting staff had requested industrial washing machines with a sluice facility to improve hygiene standards within the laundry. They told us the provider had purchased these washing machines and we saw them. This reduced the risk of cross contamination.

People told us they were happy living in the home. A staff member described the culture of the home as, "Homely, lovely atmosphere and having a good relationship with people." They told us, "If I needed care and support in the future I would be happy to live here." We observed the atmosphere was relaxed and there was a positive engagement between people and staff.

People told us the managers and one of the providers frequently sat with them and explored whether they were happy with the service provided. Staff told us they felt supported by the managers. They said the provider had made a number of positive changes to the service and through meetings and supervision they were encouraged to have a say in how the home was run.

Discussions with the managers confirmed their awareness of when to send us a statutory notification about events and incidents that occur in the home which they are required to do by law.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12, Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medication systems and practices were unsafe and placed people at risk of receiving medicines that were unsuitable for use. Practices did not protect people from the risk of accessing harmful chemicals.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17, Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not taken sufficient action since the last inspection to ensure their governance assessed and monitored the quality of service provided to ensure people's safety and welfare.