Hallmark Healthcare (Holmewood) Limited

Barnfield Manor Care Home

Inspection report

Barnfield Close
Holmewood
Chesterfield
Derbyshire
S42 5RH
Tel: 01246 855899
Website: www.hallmarkhealthcare.co.uk

Date of inspection visit: 1 October 2014
Date of publication: 12/06/2015

Ratings

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

Overall summary

Accommodation, nursing and personal care, is provided at this location for up to 39 older adults with nursing needs or living with dementia. At our visit, 28 people were living in the home. There had not been a registered manager in post at this service since August 2014.

There was no registered manager in post. A new manager had been appointed who advised they were commencing their registered manager application. 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.'

There were not always enough staff to meet people's individual care needs and people did not always receive appropriate care or treatment. People were not being fully protected from risks associated with unsafe medicines practice because their medicines were not always properly stored, recorded or given.

Summary of findings

Staff, were aware of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), but they did not fully understand or follow these when required. They did not always show whether people's capacity to consent to their care had been properly considered or authorised, when restrictions to people's freedom had been made to keep them safe.

Before our visit the provider told us they carried out regular checks of the quality and safety of the environment and people's care. However we found that their checks were not wholly effective to protect people against the risks of inappropriate or unsafe care and treatment because they were not always being followed or acted on. The provider's checks had not been consistently or proactively undertaken, which resulted in failure to identify and act on areas of concern for people's care that we found at this inspection.

People, their relatives and most staff felt that people's care and staffing arrangements were improving, but that staffing arrangements were not always sufficient to ensure people's safe supervision and delivery of their care.

Staff received most of the training they needed to perform their role and responsibilities. Plans for further staff training covered most, but not all of the areas outstanding for a few staff members.

People and their relatives felt that overall, staff had established, caring and supportive relationships with them and often consulted with them about the care they provided. Most said that staff ensured people's dignity and treated them with respect and kindness. Relatives and friends said they were made to feel welcome and comfortable when they visited the home. During the course of our inspection we saw that staff, were often caring, compassionate and respectful towards people. However, we observed some instances when staff did not always ensure people's equality, independence, dignity or choice. We have recommended that the provider continues to review and develop there are approach to meet with recognised guidance for ensuring people's equality and rights in their care.

People were supported to eat and drink and to maintain a balanced diet. People's body weights were monitored and they were given foods in the consistency they required. This helped to make sure that people's nutritional needs were being met. New menus were also being introduced in consultation with people to improve the choice of food provided, as this had been limited, particularly for people who required a soft diet because of their medical condition.

People who were able to express their views, relatives, local commissioners and some staff told us that the management of the home had not been consistent or pro-active before our inspection. All said that since the manager's appointment, they were pleased or satisfied with some of the improvements that were being made for people's care. People and their relatives knew how to raise concerns or to make a complaint.

Programmes for regular staff meetings and individual staff supervision had commenced. Staff understood their roles and responsibilities for people's care. Staff knew how to raise any concerns they may have about people's care and expressed their on-going commitment to maintaining and improving this.

Improvements had been made to protect people from harm or abuse. This included the formal monitoring of some of the known risks to people from their health conditions and the monitoring of complaints, safeguarding concerns and accident and incidents, such as pressure ulcers and falls. There were clear procedures in place for reporting the witnessed or suspected abuse of any person using the service and staff that we spoke with knew and understood these.

Contingency plans were in place for staff to follow in the event of unforeseen emergencies in the home. Since our visit the provider has assured us of some additional measures they were taking for fire safety in the home.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

There were not always enough staff to meet people's care needs and their medicines were not always safely managed.

Improvements had been made to protect people from harm and abuse and staff understood the procedures to follow in any event. Staff recruitment and emergency contingency arrangements were robust.

Requires Improvement

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

People did not always receive appropriate care or treatment. Staff did not always understand or follow the Mental Capacity Act to obtain consent or authorisation for peoples care when required.

People were appropriately supported to eat and drink and to maintain a balanced diet. Improvements were being introduced to the choice of food provided.

Requires Improvement

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

Staff did not always ensure people's equality, independence, dignity and choice.

Some improvements were being made to enhance and improve people's experience of their care. Staff usually treated people with respect and kindness and had established caring supportive relationships with them and their families, who were made welcome in the home.

Requires Improvement

Is the service responsive?
The service was responsive.

People as able and their representatives were enabled to make suggestions or raise concerns and complaints about the service and were confident they would be to and mostly acted on. Improvements were being made to enhance people's care experience and to develop a more personalised approach their care.

Good

Is the service well-led?
The service was not always well led.

People were not fully protected from the risk of unsafe care and treatment because the provider's checks of quality and safety were not always being followed or acted on.

Requires Improvement

Summary of findings

Staff understood their roles and responsibilities for people's care. They were committed to maintaining and improving people's care and understood the reasons for some changes that were being made for this.

Barnfield Manor Care Home

Detailed findings

Background to this inspection

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

We visited the home on 1 and 2 October 2014. Our visit was unannounced and the inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). 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. We also looked at notifications the provider had sent us and we spoke with the local and health authorities responsible for contracting and monitoring some people's care at the home. A notification is information about important events, which the provider is required to send us by law.

During our inspection we spoke with four people who lived in the home, six visitors, three registered nurses and three care staff, including one senior. We also spoke with the newly appointed manager for the home and the registered provider's nominated individual. We observed how staff provided people's care and support in communal areas. This included use of 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. We also looked at some of 12 people's care records and other records relating to how the home was managed.

Requires Improvement

Is the service safe?

Our findings

At this inspection people using the service and their relatives told us they felt that safer care was being provided and that there had been some recent improvements to staffing arrangements. However, many felt that there was still sometimes, not enough staff for peoples' safe supervision. A common example they gave us, was that people were sometimes left in lounge areas unattended by staff for long periods of time. One person told us, "I do have worries about overall safety when there is not enough staff around, although it isn't such a major problem lately, as it was." Another person's relative said, "It was very short staffed; it seems to be getting better, but there are still sometimes when it's not adequate."

Before our visit the provider told us that they ensured good staffing levels to help keep people safe. However, at our inspection we found that there were not always enough staff, to provide people with the support they needed, at the time they needed it. We saw a number of occasions where people had waited in excess of 20 minutes for staff assistance. Two people became quite distressed and anxious whilst they waited up to 30 minutes for staff to assist them with their care needs. In the absence of staff, one of them attempted to stand and walk, but because they were unsteady on their feet, they fell back into their chair. On this occasion they were unharmed. Their care plan showed that they were at risk of falls and required regular supervision to prevent this.

Most of the nursing staff we spoke with, felt that their ability to adequately supervise care staff and monitor people's care was compromised when there was only one nurse on duty. They said this regularly occurred during the afternoon shifts and the staff duty rotas that we looked at showed this. The manager advised that action was being taken to recruit an additional nurse. Most of the nurses and care staff felt that staffing levels were not always sufficient. They told us that risks to people accommodated on the ground floor were increased, because of the layout of the environment, people's overall mobility levels and risks relating to their dementia care needs. The manager confirmed that it was not possible to always supervise people in all areas of the home. There was no clear method of determining staffing level requirements.

We found that staffing numbers and skill mix were not always sufficient to fully protect people from the risks of unsafe care. This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not always safely used or managed. Although most people's medicines were safely stored, including controlled medicines; some people's medicines that required storage in a medicines refrigerator were not. The recorded daily temperature checks of the medicines refrigerator showed that temperatures were not always within the recommended range for the safe storage of medicines. The records for September 2014 showed that temperatures were sometimes too low and often too high, but no action had been taken to rectify this or to seek relevant advice about the potential safety and use of people's medicines that were being stored in this way. It is important to store medicines at the correct temperatures to ensure their safety and effectiveness when given.

Written procedures were in place for the management of people's medicines, including their disposal. However, staff responsible did not always follow procedures for giving and recording people's medicines. We looked at six people's medicines administration records (MARs), which showed occasional gaps in recording. They were not always signed by the nurse responsible, to show whether people's medicines had been given as prescribed, or the correct code entered for the reason they had not been given. For example, one person was prescribed a medicine to be given at weekly intervals. There was no recorded signature on the MAR to show whether the medicine had been given as prescribed when last due, and there was no recorded code to show the reason why this had not been given. Stock records showed that four tablets of this particular medicine should have been available to give to the person as prescribed. The nurse was not able to locate these and did not know whether the person had received this medicine when it was last due. It is important to keep an accurate record of people's medicines so that other staff will know exactly what medicines people have been given. This helps to ensure that people are not placed at risk from overdose or not receiving their medicines as prescribed.

We found that the registered person had not protected people against the risk of the unsafe management of medicines. This is a breach of Regulation 13 of the Health

Requires Improvement

Is the service safe?

and Social Care Act 2008 (Regulated Activities Regulations 2010), which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed one nurse giving people their medicines at lunchtime and saw they spent time to give people's their medicines safely. Some people were prescribed medicines that were only to be given when required, rather than at regular intervals or in variable doses. We looked at the arrangements for three people's medicines that were prescribed in this way. We saw that they were being safely given and that each person had a care plan which described how decisions were made about why, when and how much of each medicine was to be given. Staff training records showed that all nurses responsible for people's medicines had received regular training for this, which included an assessment of their competency. Two nurses present at our inspection confirmed they had undertaken this.

Information we held before this inspection showed that the provider had not always identified the possibility of harm or abuse or prevented it before it occurred. Between April and September 2014, there were 16 allegations of people's neglect, abuse or serious injury at the home. Subsequent investigations, co-ordinated by relevant local authority responsible for this, found that seven of the allegations were substantiated, seven were not substantiated and two were inconclusive. The investigations concluded that harm or serious injury had resulted from the neglect of four people using the service. They showed that staffing and care arrangements, including the assessment of risks to people's safety through their individual care plans, were not sufficient for people's needs to be safely met.

Some improvements had been made to protect people from harm or abuse. This included the formal monitoring of some of the known risks to people from their health conditions and the monitoring of complaints, safeguarding concerns and accident and incidents, such as pressure ulcers and falls. There were clear procedures in place for reporting the witnessed or suspected abuse of any person using the service and staff that we spoke with knew and understood these.

Staff described robust arrangements for their recruitment and related records that we looked at confirmed this. We also found that contingency arrangements were in place for staff to follow in the event of a foreseen emergency, such as a fire alarm. This included emergency evacuation plans for each person receiving care, which staff knew about. Since our visit the provider has assured us of some additional measures they were taking for fire safety in the home following consultation with Derbyshire Fire and Rescue Service.

Requires Improvement

Is the service effective?

Our findings

We found that people did not always receive appropriate care or treatment. Care staff we spoke with did not always fully understand people's care requirements. Some people's recorded needs and risk assessments for their care were not always being regularly reviewed and their care plans and relevant daily care charts did not always show the instructions that staff needed to follow for people's care. Where these conflicted, we asked staff to tell us about the needs of those people and found they held differing views. For example, the minimum amount of drinks people needed each day and people's oral, eye care and skin/ pressure area care needs. People's records showed significant differences in the amount and frequency of drinks offered to each person daily. We also saw that one person's care plan had not been updated to reflect the instructions from an external health care professional for their body positioning, relating to their wound and pressure area care. Records of the person's daily care showed that staff had continued to follow a previous instruction for this. It was important that care staff understood and followed the health professional's instructions for the person's wound to heal.

We found that the registered person had not fully protected people against the risk of receiving of inappropriate care. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2010).

Most of the staff we spoke with, were aware of the key principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA is a law providing a system of assessment and decision making, to protect people who do not have capacity to give consent themselves to their care, or make specific decisions about this. However, staff did not always follow the MCA when required or ensure that people's consent was properly obtained for their care. For example, we observed that staff prevented one person from leaving the home on more than one occasion. Staff explained that they sometimes needed to do this in the person's best interests, to keep them safe. However, steps had not been taken to obtain a formal DoLS authorisation from the relevant authority, which is required when a person's freedom is being restricted in this way.

The provider's records did not always show whether people's capacity to consent to their care, or their communication needs for obtaining their consent, had been properly considered. Staff told us about a two people who were not able to consent to their care because of their medical condition. Both of these people were both restricted to receiving nursing care in bed. Staff explained that bed rails were being used for each person in their best interests to keep them safe. The provider had not reviewed their practice against the most recent case law changes for DoLS during 2014, to consider the action they may need to take in view of those restrictions.

We found that the registered person had not protected people against the risk of care being provided without the consent of a relevant person. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2010), which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff we spoke with told us that they had not received all of the training and supervision they needed. The provider's staff training matrix record showed that a few staff had not received training in eight of the nationally recognised areas of role specific training. The manager showed us their action plans for this. The plans showed that further training was organised for staff relating to people's nutritional care during October 2014. They also showed that each care staff would receive individual supervision by the end of October 2014, with an on-going supervision plan to the year end. However, their training plan provided, dated October 2014 did not fully account for all of the staff training deficits.

Before our inspection, information about this service was shared with us by local health and social care commissioners. This showed that people's health care needs had not always been met, but that improvements were being made by the provider.

At our inspection, three people receiving care, most people's relatives and a visiting professional that we spoke with all confirmed this but felt confident that improvements were being made. Two people's relatives told us about the care each person was receiving relating to their mobility and nutritional needs. One said, "She gets the assistance and care she needs now to prevent her falling."

Most relatives we spoke with felt that people's care was improving and were more confident that their family members would receive the care they needed. One

Requires Improvement

Is the service effective?

person's relative told us, "We are satisfied that they are doing as much as possible to provide the right care now." Staff we spoke with knew about many aspects of people's health needs. We observed that the nurse in charge exchanged relevant information about changes to some people's medical conditions and their health care needs during a handover at a staff shift change. This included where advanced decisions had been made about people's care and treatment, in the event of their sudden collapse. People's care records showed who was involved in the decision making process and the reasons for any decisions that were made in people's best interests

Work was in progress to improve the assessment, monitoring and delivery of people's care through the development of a more robust care planning system. Some people's risk assessments and care plans that we looked at were up to date and showed that their health status, relating to their emotional, nutritional and wound care had either improved or was being maintained. They also showed that referrals were made to outside health care professionals for advice about people's care and treatment when required and that people were usually supported to access relevant health care services, such as appointments with the GP or hospital appointments. One person's relative told us, "I am informed about changes to their care and medicines and the doctor was called promptly when needed."

Staff supported people to eat and drink and helped them to maintain a balanced diet. Some people who used the service had a reduced appetite or difficulty eating and drinking. People's care plan records showed that their body weights were monitored and we saw that people were given their food in the consistency they needed. For example, when they required a soft diet. One person's relative told us, "She has special dietary needs and had lost quite a lot of weight; but the staff understand this now; she gets the care she needs and has put on weight again."

A few people, who were not able to eat and drink because of their medical condition, received their nutrition by enteral feeding. This is the delivery of nutritionally complete food directly into the stomach, through a surgically fitted device. The nurse responsible for administering people's nutrition in this way; told us that they had received training for this and people's written care plans provided clear instructions for nursing staff to follow. This helped to ensure that people's nutritional needs were being properly met.

People and their relatives told us that the choice of food provided was limited, particularly for people who required a soft diet because of their medical condition. This reflected what we saw at our visit. However, the manager advised that food menus were being reviewed to improve this. They showed us a sample copy of one of their revised weekly menus, which were due to be introduced in consultation with people and their relatives. This showed that improvements were being made for people's food choice and suitability, which included soft diets.

Requires Improvement

Is the service caring?

Our findings

Overall, people and their representatives felt that staff had established caring supportive relationships with them and often asked them for their views of the care provided. We received many positive comments, which included, "Staff are marvellous; always patient and kind and take their time," and "Staff are all respectful and polite." Most said that staff ensured people's dignity and treated them with respect and kindness. People's care records showed the key names and contact details of those who were important to them and people's relatives and friends that we spoke with said they were made to feel welcome and could visit at any time to suit the person receiving care.

During the course of our inspection we saw that staff, were often caring and respectful towards people and ensured their privacy needs were met. For example, when they supported people to engage socially or with their mobility and personal care needs. We saw that staff gently guided one person who became agitated to a quieter area, where they stayed with them and chatted to them in a reassuring manner. The person responded positively to this and became calmer and happier.

The manager, who told us about some of the work they had commenced to enhance and improve people's experience of their care and to improve staffs' knowledge and understanding of peoples' diverse needs for their care. This included the introduction of picture menus and equipment to assist people to make independent meal choices and some dementia care and communication training for some staff. A few care staff told us about training they had more recently undertaken for this. One said, "The new manager is more focused about dementia care and is helping us to understand how to support people we have difficulty communicating with."

However, we observed a few instances when staff did not always ensure people's equality, independence, dignity and choice. Many people were not able to verbalise their choices and wishes for their care because of their dementia care needs. We saw that people were not always offered choices at mealtimes; staff did not always tell people about the food they were eating and did not use the picture menus available to help people. Most people were not offered the choice and support to sit and eat their meals at one of the dining tables that were available, but not set. One person's relative told us that the person had always preferred to eat their meals at the dining table but this was not facilitated.

We observed that there was a delay in staff supporting someone to change their soiled clothing when they needed assistance, which did not promote their dignity or wellbeing. We also saw one staff member verbally responded to someone in a way, which did not promote the persons' equality or show full empathy and understanding for their disability from their medical condition. We recommended that the provider continues to develop their care approach to meet with recognised guidance for ensuring people's equality and rights in their care.

Good

Is the service responsive?

Our findings

As a result of people's expressed views about the service, a few people able and people's relatives we spoke with, all told us that some changes were being made to improve people's care. One person said, "Being able to get a staff member to help my relative when needed is not such a one-off now, it's changing for the better." All said that staff often supported people promptly when needed, in as much as they were able to.

People as able and their relatives knew who to speak with about any issues or concerns they may have and how to make a complaint. Many specifically commented that they felt more confident of late that they were being listened to. One person said, "They are trying hard to get it right and listen now." Two people told us they had complained about the laundry system, because of people's clothing getting lost or muddled with others. Both said this had been an on-going issue but were confident that the manager was acting on their concerns. Records of staff meetings that we looked at showed that this had been discussed with staff together with the proposed actions and monitoring to resolve matters. Another person told us about a suggestion they had made to the manager and were pleased that this had been acted on. They said, "There was a side room full of junk; I suggested they clear it out and now it's a small lounge come quiet room with a TV that we can use."

Information about how to complain was openly displayed in the home in a large print format, together with information about advocacy and support for this. Records of complaints showed that because one person was dissatisfied with the outcome of the provider's investigation of their complaint, that this was being progressed and reviewed through their own and the local authority's procedures.

People's own rooms that we looked at were personalised and had meaningful items on the door to help their recognition, such as photographs. Resting areas had been created in appropriate areas around the home, which we saw benefitted some people who preferred to move around the home a lot. The areas provided additional seating, small tables and snacks and drinks for people. A large staff photo board was displayed to help people and their relatives to recognise staff.

An activities co-ordinator had been recruited, who engaged people in a range of group and individual activities. For example, reminiscence, music and gently exercise. During our visit we observed that a planned coffee morning was held with a raffle and a music session. Many people had significant dementia care needs and they were encouraged and supported to engage in this in a way that was meaningful to them and at their own pace. Staff explained that in the past one person enjoyed house work, one liked to go dancing and two others had active social lives. We saw those people were engaged accordingly to help with tea and coffee cups or with organising and drawing the raffle or to dance. The atmosphere was calm, but lively and a few people who had been sitting quiet and withdrawn with eyes closed, responded to this and became socially engaged.

One person told us that they wished to return to their own home and that staff were supporting them to trial this. They were pleased that arrangements were being made in consultation relevant external health and social care professionals to support them in a home visit to assess how their needs could be met there.

Staff were not able to directly consult with most people about their daily living and lifestyle preferences and routines due to the level of their dementia. People's care records showed some of their known daily living routines, lifestyle and care preferences, which staff, mostly knew. The information recorded about one person's known hobbies and interests was not being used by staff to inform and support their daily living experience. However, work was in progress to address this with staff and to develop a more personalised and enhanced care experience, which included consultation with people's relative or known representatives.

Many people's relatives referred to the 'family meetings,' which had been commenced with them. All felt these were a positive step forward and were valuable and constructive. One person's relative said, "It's what we wanted to happen, it's not just a talking shop, we are being asked what we think and what we want for the home and people's care." A few people using the service and relatives we spoke with gave us examples of changes and improvements that were being made or were in progress, which they felt had resulted from their views. This included people's meals, recreational, social and occupational activities and the environment, to reduce unpleasant odours and to enhance

Good

Is the service responsive?

people's dementia care experience. One person said, "The kitchen needs a bit of a rocket - the food is plentiful but repetitive, but the manager has looked and listened and is doing something about it."

Requires Improvement

Is the service well-led?

Our findings

Before our visit the provider told us they carried out regular checks of the quality and safety of the environment and people's care. However, we found that their checks were not wholly effective to protect people against the risks of inappropriate or unsafe care and treatment because they had not always being followed or acted on. The provider's checks had not been consistently or proactively undertaken, which resulted in failure to identify and act on areas of concern for people's care that we found at this inspection. This included medicines, care planning and delivery, staffing arrangements and the use of Mental Capacity Act 2005.

We found that the registered person's arrangements did not always inform or ensure improvements to the quality and safety of people's care or fully protect from risks to their health, safety or welfare. This is a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010.

There was no registered manager in post at this service. The manager was new in post since September 2014. They told us they were commencing their registered manager application.

A few people who were able to express their views, relatives and commissioners told us that the management and provider oversight of the home had not been consistent or pro-active. Many felt this had led to some of the failures in care that were mostly identified through complaints and safeguarding concerns investigated by the relevant local authorities between May and September 2014.

We received many positive comments about the new manager who was described as "enthusiastic" and "providing a good front of house presence." All those we spoke with were fairly optimistic and hopeful about the change of leadership and the improvements being made, but with a few reservations about whether the improvements would be sustained.

The manager told us about some of their agreed aims and objectives for people's care. This included a review of the culture and care values of the service in consultation with people who lived, worked or had an interest in the service.

The manager also showed us their action plan, which they had commenced to improve quality and safety of the service and people's experience of their care through staff training and targeted on-going supervision and performance monitoring arrangements.

Staff said the manager was accessible and approachable and that they were confident and knew how to raise any concerns they may have about people's care. Staff, understood their roles and responsibilities for people's care and were provided with key policy and procedural guidance for this. For example, communicating and reporting accidents and incidents and changes in people's conditions and needs.

The manager had established a programme of regular staff meetings and showed us the minutes of two that were recently held. They showed a good attendance, with relevant discussions about the service aims, people's care and some of the changes and improvements that needed to be made and why. They also showed that staff's views were being sought about these. Staff were positive about the changes being made and understood the reasons for them. Most expressed their commitment to maintaining and improving people's care.

A review of clinical governance arrangements was underway and we saw that regular checks had commenced, with some actions taken from this to help to improve and maintain people's nutrition, skin and wound care. The provider also carried out periodic checks of nursing staff's individual registration status to make sure they were registered as fit to practice

Some improvements were being made to protect people from unsafe care. This included the formal monitoring of some of the known risks to people from their health conditions and the monitoring of complaints, safeguarding concerns and accident and incidents, such as pressure ulcers and falls.

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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff numbers and skill mix were not always sufficient to fully protect people from the risks of unsafe care and treatment. Regulation 18(1).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered persons were not fully protecting people against the risks of unsafe care and treatment because people's medicines were not always properly or safely managed. Regulation 12(1) (g).**

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

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

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person's arrangements did not always inform or ensure improvements to the quality and safety of people's care, or fully protect people from risks to their health, safety or welfare. Regulation 17(1) (2) (a) & (b).