Meadows Edge Care Home Limited

Meadows Edge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Meadows Edge Care home is a residential care home providing personal and nursing care to up to 45 people in one adapted building. The service provides support to both older and younger adults including two people with learning disabilities. At the time of our inspection there were 37 people using the service.

People's experience of using this service and what we found
Medicines were not managed safely, this posed a risk to people's health. People were not supported safely to receive medicines, this risked a negative impact on people's health. Risks to people were not always assessed or mitigated. Risks in people's environment were not always identified and managed. Some actions were taken by the registered manager to manage medicine and environmental risks once they were highlighted by inspectors.

Incident recording was inconsistent and did not include enough information to improve care and support in the future. Lessons were not learned from incidents.

Hygiene practices did not support the prevention of infection. We were assured about other processes at the service to protect people from infection.

The provider failed to identify and address risks to people through quality assurance processes. Following a discussion with inspectors, some actions were taken by the registered manager to improve systems at the service.

People's needs were not always assessed effectively and care plans were not always detailed with people's needs. Staff told us of people's needs which were difficult to manage and information was not available to staff to support with this in care plans.

Staff did not always have training in relation to people's specific mental and physical needs. The registered manager stated they would arrange for this training to take place.
Areas of the environment had been updated but some areas of the service needed further improvements.

Policies and systems in the service did not always support people to have maximum choice and control of their lives as staff had not been supported to complete training in the Mental Capacity Act (2005). However, we observed staff to support people in the least restrictive way possible and in their best interests.

People were supported by caring staff in most instances, but there were some examples of staff not using compassionate language. Staff upheld people's rights to privacy and dignity and people were supported with decision making where needed. Relatives felt people received person-centred support and gave examples of where people had experienced positive outcomes.

Staff understood safeguarding and incidents of abuse were reported to the local safeguarding authority to help keep people safe. Staff were recruited safely and staffing levels were safe. People and relatives felt the service was safe.

People were supported to maintain their nutrition and hydration effectively. People were supported to access external healthcare services. Staff and relatives felt engaged by the service.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 04 March 2020). The service remains rated requires improvement. This service has been rated requires improvement or inadequate for the last three consecutive inspections.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We inspected and found there was a concern around the Mental Capacity Act within the service, so we widened the scope of the inspection to include the key question of effective.

You can see what action we have asked the provider to take at the end of this full report. The provider took some actions to mitigate the risks identified at this inspection and some of this was effective.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has remained requires improvement based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Meadows Edge Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to people's health and safety, governance and staffing at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Meadows Edge Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by 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 care service.

Service and service type
Meadows Edge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Meadows Edge is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced. Inspection activity started on 15 September 2022 and ended on 27 September 2022. We visited the service on 15 September 2022.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used information gathered as part of monitoring activity that took place on 11 February 2022 to help plan the inspection and inform our judgements. We also sought feedback from the local authority who work with the service. We used all this information to plan our inspection.

During the inspection
We spoke with three people using the service and ten relatives of people using the service. We spoke with seven staff members and the registered manager. We also observed care and support given by staff.

We reviewed four people's care plans and risk assessments. We also reviewed a range of other documents related to the inspection.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Peoples medicines were not managed safely. Records showed the clinical lead nurse had signed several medicine administration records (MARs) prior to a medicines round taking place. This meant people's medicines were marked as given before they had consented to take them. This increased the risk of error and put people at risk of not receiving their prescribed medicines correctly.
- Records relating to storing and management of controlled drugs were not in line with best practice. For example, we found that records were not always double signed by two staff members. It is good practice that two competent staff members are always involved with controlled drugs to spot and track discrepancies.
- Medicines records were not always accurate which increased the risk of people not receiving medicines as prescribed. Records for one person documented they had been given too much, or too little pain relief on multiple occasions. As this had not been identified or investigated, we were unable to determine if this was an actual error, or a recording issue.
- There was a risk people may not receive 'as required' medicines as prescribed because clear guidance was not in place. For example, one person required medicines in the event of a seizure, however there was no further detail about when to give this.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong;

- Risks to people were not always assessed robustly. Two people were known to display emotional distress which put themselves, people and staff at risk of harm. For example, one person was recorded to be physically aggressive towards carers in incident records. This person could have presented as a physical risk to other people at the service. The person did not have a risk assessment in place to inform staff how to safely manage this risk.
- Opportunities to learn from incidents where people had become distressed had been missed. There was no effective system to record important details such as times, staff involved or what worked and didn't work.
- Information recorded following accidents and incidents did not always include lessons learned. For example, there were eight recorded falls in total for the months of June and July 2022 and no learning from these incidents was documented.
- The environment was not always safe. Wardrobes had not always been fixed to walls which presented a risk to people when using them as they could have fallen when using them. It also presented a risk to people who may use furniture for support as an aid while walking.

Preventing and controlling infection
● We were not assured the provider was promoting safety through the service layout and their hygiene practices.
● The provider had created a new laundry room as the previous laundry room did not promote good IPC practices. However, we saw the old laundry room was still being used, with some clean linen being stored on painted wooden shelves which were chipped. This created a contamination risk. The registered manager told us this was only used when there was excess laundry and following the inspection site visit it was no longer in use as the washing machine had a fault.
● Other areas of the home had damage or were unhygienic, which meant there was an increased risk of harbouring bacteria. For example, one person's room had a cracked sink. The same person's wheelchair was worn, with foam visible through the seat cover. There was also a shower chair in a shower room which had heavy staining.

The provider had failed to ensure that medicines were managed safely and that risks relating to the health, safety and welfare of people and the service environment were robustly managed, monitored and assessed. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our feedback, the registered manager took some actions to give assurances of ongoing medicines safety. This included changing the clinical lead nurse at the service. The registered manager also told us they took action to address environmental risks, such as fixing the wardrobes to walls.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
Visiting in care homes
● The provider facilitated visiting in line with government guidelines. Alternative arrangements, such as window visits and video calls were made available in times of COVID-19 outbreak to continue to support people to have contact with relatives and friends.

Systems and processes to safeguard people from the risk of abuse
● People and relatives we spoke with generally felt the service was safe. Describing one person, a relative told us, "They're 100% safe there." One person was less sure when asked if they were safe, stating "yes and no." This was due to their concerns that staff were not locking the person's door for them to stop other people coming into their room. When this was raised with the registered manager, they spoke with the person and gained consent to lock their door to make them feel safer. Staff were still be able to access the person's room when support was needed.
● Staff had up to date safeguarding and whistleblowing training and showed an understanding of these procedures. They also had access to up to date policies.
● Incidents of abuse or alleged abuse were raised to the local safeguarding authority where required. The provider followed local safeguarding policy and recorded low-level incidents with actions taken.

Staffing and recruitment

● There were enough staff to meet people's needs. Staffing levels were in line with a dependency tool being used at the service. Staff told us they felt staffing levels were safe. Some staff members told us an extra staff member completing a 'twilight' shift each evening helped to take pressure off them in the evening when supporting people to go to bed.
● Relatives had mixed comments on staffing. One relative also told us, "Most of the time there are enough staff there. When I've gone in there, there are quite a few on. Most of the time I see the same old faces." Some relatives, however, were concerned about staffing levels and told us they thought the staff were very busy, worked long shifts and sometimes had a slow response to call bells.
● Staff were recruited safely. Staff had relevant information in their staff files to ensure they were suitable for their roles. Staff had Disclosure and Barring Service (DBS) checks in place. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were not always assessed effectively. For example, one person's care plan was not consistent with incident records. The person was documented to have physically assaulted staff and to throw items. Staff also told us they found the person's distress difficult to manage. The care plan failed to inform staff on how to best support this person at times of distress.
● Another person, who required support from a hoist to move from their bed, had no further information in their care plan about the sling type to be used for hoisting or that they used bed rails. This put people at risk of not receiving safe and appropriate support from staff who were not familiar with their needs.

The provider failed to ensure risks to people were effectively assessed. This is a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Recognised risk scoring tools, such as the Waterlow score to measure skin integrity risk, were used consistently by the service. Where these tools highlighted concerns, appropriate action was taken.

Staff support: induction, training, skills and experience
● Staff had not always received training in the Mental Capacity Act (2005). The registered manager told us that they did not have the MCA as one of their mandatory training areas. This put people at risk of not being supported in line with law and guidance.
● Staff did not always receive training specific to people's needs. Training records showed staff had not received training to support people at times of agitation or around mental health needs. One staff member told us, "We would benefit from training around mental health. I have mentioned it loads of times to [staff member]. Now we're getting different people with different needs." This risked staff not being able to meet people's support needs.

The provider had not ensured staff had received appropriate training to meet people's needs. This was a breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following feedback with the registered manager, they stated they were ensuring staff received training in the MCA and they were sourcing practical training for staff around people's emotional distress. They also stated they would arrange in-person handovers from staff at people's previous settings for their own staff where their care was complex.
● The provider's training records showed that staff were up to date in training determined as mandatory by

the provider, such as moving and handling. Staff also had access to a mixture of practical and online training. We saw a staff member demonstrate their moving and handling knowledge, by supporting one person to sit up straight safely so they could eat their meal.
● Staff received an induction where they completed training and observed a senior member of staff for a period (shadowing). One staff member said, "I did shadowing for a month and it was useful. It was a new environment for me, so it was really good."
● Staff received regular supervisions and appraisals which they felt supported their progression and allowed them to raise any concerns.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Although training had not been completed in the MCA, the registered manager and staff we spoke with did have an understanding of the MCA and used its principles at the service. We observed people were asked for their consent and be supported to make decisions were appropriate.
● The provider had obtained legal authority to deprive people of their liberty when it was needed. There were no conditions recorded on people's DoLS authorisations.

Adapting service, design, decoration to meet people's needs
● Storage of equipment was not always effective. For example, a hoist was stored in the entrance of a bathroom throughout the day and this blocked access to use the toilet for people. The registered manager told us this bathroom was not being used by people. This reduced people's opportunity to access a toilet at the service.
● The service had undergone maintenance work throughout the building, with updates such as changes from carpet to vinyl flooring in most areas. However, other areas of the building still required updating. For example, a glass fire exit door had been visibly damaged from the outside and although this was still functioning and not a risk to people, it presented as a negative image in the environment. The registered manager told us they were waiting for this to be fixed but it had been this way for several weeks.
● The environment was not always dementia friendly. Rooms around the service did not always include signage to support people with memory loss. For example, the manager's office did not have a sign to support people to find it. While, some people's rooms had external memory boxes, decorated with the person's name and personal images, other rooms did not have people's names on. Several rooms had name stickers on doors, but these were often peeling off the doors and not always readable. The registered manager told us these were in the process of being changed and a person was known to peel these off doors.

Supporting people to eat and drink enough to maintain a balanced diet

● Staff were observed to support people at mealtimes; however, some practices could have been improved. We observed people were given their main meal at the same time as a bowl of soup. This meant that people's food could have become cold while they were eating. We also saw one person's meal had a plate guard on the wrong side of the plate, so it was not effective in supporting them. This suggested staff did not understand its use.

● The latest advice from healthcare professionals around nutrition was not always highlighted in care plans. For example, the review section of one person's care plan stated that the person was to receive thickened fluids from a spoon. This had not been updated in the main body of the care plan. Although there was no observed impact of this, there was a risk of the information being missed by staff, increasing the risk of choking.

● People's nutrition and hydration was monitored effectively. Food and fluid charts were in place for people at risk of malnutrition or dehydration. These were reviewed daily by senior staff members to identify if staff needed to support people more with food and fluids. We also saw evidence of staff acting where needed, such as supporting people onto supplements where people had experienced weight loss.

● Kitchen staff were aware of people's specialist dietary needs. They had access to information on who required softer diets, diabetic friendly diets as well as people's allergies. They told us they were made aware when new residents had specific dietary risks to ensure risks to them were safely managed.

● People were offered a choice of meal prior to lunch being served. We observed one person ask for something else to eat as they did not want to eat what they were given. The person was supported to have a different meal.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● Staff supported people to access external healthcare services such as the hospital. One relative told us, "They took [my relative] for hospital appointments when I couldn't go."

● Referrals were also made to healthcare professionals, such as the community psychiatric nurse (CPN), in response to concerns about people's presentation and mental health. We saw that a referral had been made to a CPN following an incident where one person had an altercation with another person at the service.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question requires improvement. At this inspection, the rating for this key question has remained requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- Staff did not always use compassionate language when describing people at the service. One staff member we spoke with described people who required assistance with their food and drink as, "the odd lazy one." In an incident record, a staff member had also stated they had, "somehow managed to get [a person] dressed." Staff were therefore not always respectful of people's care and support needs.
- Most interactions we observed between staff and people were positive and promoted their dignity. However, we saw one staff member tell a resident to blow their nose in a forceful manner. Concerns around the way staff spoke with people was also raised at the last inspection. This was raised to the registered manager at the time of inspection, who acted by contacting the agency who supplied the staff member about potential training.
- Staff told us about ways in which they promoted people's privacy and dignity. Staff told us they always took care to knock on doors and close curtains to maintain people's privacy and dignity. We observed staff knocking on doors before entering people's rooms.
- People and relatives told us that staff were kind and caring. One relative said, "[My relative] used to work at [name of the workplace], and thinks they still do. They gave them a badge saying head interviewer. That was a lovely touch." A person also said, "When [staff] come in the morning, they are all very careful about making sure I am alright and not to hurt me. They are very caring."
- Several people from different cultural backgrounds lived at the service and staff tailored their support to them where possible. For example, during the medicines round, we saw a person who was not fluent in English was reassured by a second staff member in the person's first language. The staff member took time to explain what their medicines were for and the person consented to take their medicines following this reassurance.

Supporting people to express their views and be involved in making decisions about their care

- The provider did not always ensure staff had all available information to support people with their decision making. One person's care plan stated they were unable to communicate their needs. However, the registered manager confirmed this individual could communicate with non-verbal gestures. This put the person at risk of not being supported to make their own decision by staff.
- Staff spoke with people and relatives to aid decision making about care. We observed people were asked about preferences by staff, such as if they needed pain relief medicines.
- One relative also said, "When I talk to the staff they seem to listen. They seem to want to work with me. The signs are they are listening to me." Another relative stated, "They know [my relative] what they like, and

make sure they have what they want."

● We also saw that people received support with their own preferences. One person had food items in their room as they had requested this.

● People had access to advocacy when it was needed and multiple people at the service had independent advocates in place to support their decision making.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider failed to effectively identify and respond to concerns at the service. For example, errors identified in controlled medicines administration, as outlined in the safe section, were not identified by medicines audits. The medicines audit had also repeatedly identified that not all medicines trained staff were up to date with medicines competencies, but no recorded action was taken. This had not improved since the last inspection, where concerns were also identified with the medicines audit, leaving people at risk of a negative impact on their health.
- The provider failed to operate effective systems to monitor and record incidents where people displayed emotional distress. The system in place was informal and often did not prompt staff to record important information which could have been learnt from to tailor people's future support to achieve positive outcomes. The registered manager also told us they did not have oversight of behavioural records completed by staff, so did not review or learn from these incidents to inform better care planning.
- The provider failed to have effective oversight of systems and processes at the service. The medicines audit was carried out by the clinical lead nurse and there was no recorded system in place to check medicines audits were completed correctly or were effective. The clinical lead nurse had also previously been identified by the registered manager as completing MARs incorrectly, but there was no ongoing record of checking of their competency. Consequently, during this inspection, we found the same thing happening again.
- The provider failed to always follow their own policies and procedures. The providers own MCA policy stated that staff were to receive training in the MCA. As outlined in the effective section, there was no evidence of staff having completed this training.
- The provider failed to achieve and sustain compliance with regulations. The service has been rated requires improvement or inadequate for three consecutive inspections. Although the provider was not in breach of regulation at the last inspection, the provider had failed to address known issues to achieve an overall good rating.

The provider failed to ensure that effective governance systems were in place. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Following our feedback, the registered manager took some actions to mitigate these risks. This included putting a new incident recording system and a new system for auditing medicines.
- Some systems were used effectively by staff to identify and manage risks to people. For example, night

staff checked people's food and fluid intake charts and if any concerns were flagged the next morning, so day staff were aware of any risks.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider did not always use a person-centred approach. As explained in the effective section, care plans did not always include specific information to ensure people received personalised care. However, there were some examples of person-centred care. For example, one person was supported with a letter card to communicate with staff.

● Relatives and people, however, told us staff supported people in a person-centred way giving some evidence of good outcomes for people. One relative told us, "Staff do sweet things, they chat to [my relative], they bring them in cake. It was [my relative's] birthday last week and they really made them feel special." Another relative said, "[My relative] looks better than when they were at home, they look well cared for there. [Staff] even manage to shave them. Before, they wouldn't shave."

● The registered manager identified some people's progression at the service as key achievements. Speaking of one person, the registered manager said, "We couldn't get them out of their room. Now they spend all day in the lounge. I think they feel more safe and relaxed enough to see that this is their home."

● The registered manager understood the duty of candour. They told us about an incident where a person had left the service unsupervised and they contacted the family to apologise for the incident. One relative told us, "They keep me informed with any issues. Anything untoward and they tell me. I have a good rapport with them."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Relatives told us that the registered manager and staff engaged with them and they had good relationships with them. One relative told us, "Both the manager and deputy are amazing, anything you want to say they listen to you, and carry it through. They take time with the new staff to learn what's going on. Anything I want to know they keep me up to date. I've had meetings when I've needed them, they are really responsive."

● Staff also felt the registered manager was very approachable and if they needed to raise concerns, they would be dealt with in a fair way. However, one staff member raised concerns with us which they did not feel comfortable raising through the whistleblowing procedure due to fear of repercussions from more senior members of staff. This concern was reported to the registered manager and appropriate action was taken to investigate.

● The registered manager and staff told us they had regular meetings to discuss both people's care and staff-related issues. Staff told us they have input in these meetings. We saw evidence of staff meetings taking place.

● The service worked closely with other agencies. We saw evidence of information around healthcare assessments within people's care plans for staff to follow. One relative also told us, "I've met the manager and they are in regular contact with [my relative's] social worker. They seem to be on the ball."

This section is primarily information for the provider

Enforcement actions

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

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 provider failed to ensure risks associated with medicines administration, infection prevention and control and people's health and safety were managed. Risks to people were not adequately assessed.

The enforcement action we took:

Warning notice was served.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have sufficient oversight at the service. Quality assurance systems were not always in place and did not always identify risks and errors which left people at risk of unsafe care. The provider did not always follow their own policies and procedures.

The enforcement action we took:

Warning notice was served.

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 The provider failed to ensure that staff had received appropriate training to support people safely and in line with the law and guidance.

The enforcement action we took:

Warning notice was served.