Sanctuary Care Limited

Briarscroft Residential 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Briarscroft Residential Care Home on 27 February 2017 and it was unannounced. At our last inspection in October 2016 we found that there was a breach in regulations because the management of medicines did not ensure people received their medicines as prescribed. We found the provider required improvement in all five areas we looked at: safe, effective, caring, responsive and well led. At this inspection we looked at all five areas again and checked whether improvements had been made and sustained in the management of medicines.

Briarscroft Residential Care Home can provide personal care to up to 66 people. At the time of our inspection there were 62 people living in the home.

There was a registered manager in post but not available during our inspection. 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.

People were not always receiving their medicines as prescribed because sometimes staff signed the medicine administration record to show medicines had been given but they had not always been given. Although staff had received training in giving medicines safely they were not always following the correct procedures and following up with the doctor if people were not taking their medicines. We found that the management of medicines had not improved sufficiently to ensure that people received their medicines as prescribe and we are considering further actions we may take.

We saw that some improvements had been made to the auditing and monitoring of the service but further improvements were needed to ensure that the service improved and improvements were sustained.

People told us that staff were busy and they thought that there could be more staff available however; everyone told us that their needs were being met.

People were kept safe because staff were knowledgeable, skilled and able to meet people's needs in a caring and compassionate way. Staff were supported through training and meetings to meet people's needs and to have opportunities to raise any concerns they may have. Staff were knowledgeable about the actions they should take in emergency situations.

People were treated with dignity and respect. Staff understood the importance of gaining consent and giving people choices about the care they received. People's human rights to liberty and making decisions were protected because the appropriate actions were taken. People were supported to remain as independent as possible.

There were group activities for people to be able to take part if they wanted. There were individual activities available for people if they preferred. People told us that they knew who to talk with if they had any concerns but they hadn't had any as they were happy with the service they received.

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

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.

People did not always receive their medicines as prescribed.

There were sufficient staff to meet people's needs but some people felt additional staff would be beneficial. Recruitment processes ensured that suitable people were employed to care for people.

People were protected from the risk of abuse because staff understood their responsibilities and knew how to raise concerns if needed. Risks associated with people's individual needs were assessed and managed.

Is the service effective?

Good

The service was effective.

People were happy with the support they received from staff that were trained and knowledgeable about their needs.

People were supported to make decisions based on their capacity and asked for consent were they were able to give consent. The appropriate actions had been taken to protect the rights of people unable to make decisions about some aspects of their lives.

People were happy with the food and drinks they received and received the support they needed to remain healthy.

People's health needs were met through the involvement of a variety of healthcare professionals.

Is the service caring?

Good

The service was caring.

People were treated with care, respect and dignity by staff that knew them well.

People were encouraged to maintain their independence as far

as possible and supported to express their views and make choices.

Is the service responsive?

Good

The service was responsive

People were supported by staff who responded to their needs appropriately.

People's needs and preferences were assessed to ensure they would be met in their preferred way.

People had access to a variety of activities on a daily basis. There were systems in place to listen to people's complaints or concerns.

Is the service well-led?

Requires Improvement

The service was not well led.

Systems were in place to monitor the quality of the service provided but were not always effective at identifying where improvements were needed.

Staff felt supported and listened to by the registered manager.

Briarscroft Residential 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 checked 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 service to check that they had met the requirement notice issued at our last inspection of October 2016 in respect of medicines management. We also took the opportunity to look at all the areas we had inspected at the October 2016 because all areas had been rated as require improvement.

The inspection team consisted of a lead inspector, pharmacist inspector and two experts-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.

In planning our inspection we looked at information we had received about the service. This included feedback from people using the service directly and looked at websites such as NHS choices for comment sand feedback about the service and notifications received from the provider. Notifications include information about accidents, incidents and safeguarding's that the provider is legally required to tell us about.

During our inspection we spoke with 12 people that used the service, 10 relatives, and five staff including care staff, domestic and catering staff as well as the deputy manager, regional manager and care development manager. We looked at the care records of four people to check they were receiving care as planned and two staff to check they had been recruited safely. We looked at records including audits and training records to check on the monitoring of the service.

Some people at Briarscroft were living with dementia and not able to speak with directly regarding the care

they received. We used the Short Observational Framework for Inspectors to get a view of the quality of care they received.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of 03 and 04 October 2016 we found that people were not always getting their medicines as prescribed. A requirement notice was issued telling the registered manager and provider that improvements in medicines administration were needed. Following that inspection we received an action plan dated 12 December 2015 describing the actions that had been taken to address our findings. At this inspection we found that people were still not always getting their medicines as prescribed and as a result we have taken enforcement action to ensure improvements are made. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A member of the CQC medicines team reviewed the management of medicines and looked in detail at the records for twenty six people living in the home. One person told us, They give me my medication every day, no problem there."

Medicines, including tablets, eye drops and creams, were not being given to people as prescribed. We saw occasions where medicines remained in blister packs however signatures had been recorded on the (medicine administration record) MAR charts to indicate medicines had been administered to people at those dates and times. This demonstrated that care staff had signed as having administered medicines when the person had not received their medicines. If medicines are not administered as prescribed this may result in deterioration in a person's medical condition. The managers in the home said they were looking at taking actions in relation to individual staff members and their actions.

We saw that for one person using eye drops the MAR chart had been signed to indicate these had been administered for the first three weeks of the administration of medicine's cycle. However, the bottle of eye drops had not been opened. The member of care staff who had signed to indicate administration told us that she had mixed these drops up with another eye drop that the person was receiving. Therefore, in addition to not receiving the prescribed treatment, we were unable to determine whether the person had received a double dose of the second eye drop. Incorrect administration or omissions of these medicines may result in deterioration in the person's eye condition.

Where people were unable to take their medicines at the time of medicine rounds due to being asleep we did not see evidence that the medicines had been offered at alternative times or that prescribers were being contacted to discuss alternative treatment regimes. These included medicines for Parkinson's disease which need to be given at the specified time to be effective.
Three people had information within their notes to suggest they may need to be given their medicines by disguising them in food or drink (covertly). Although best interests plans included information to show the appropriate people had been consulted in this decision we saw that the information detailing how certain medicines could be concealed was insufficient and in one case was incorrect.

Records were kept for people who had medicines given via a skin patch to ensure staff were able to correctly rotate the sites of application. However, we saw that for certain patches the charts did not show adequate rotation of application site to ensure people were not at risk of skin reactions. This was rectified during our

inspection.

Charts were used by care staff to record the application of creams and ointments. We looked at the charts for eight people and saw they were not fully completed. We saw that four people's cream charts had clear information about how their creams and ointments were to be used but the charts did not indicate that administration was in line with the prescribed frequency. Instructions on other cream charts were unclear stating the cream was to be applied 'as directed' so we were unable to tell if creams (or creams and ointments) were being used as the prescriber intended. The provider was unable to show us where prescribers had been contacted to clarify instructions.
We were not assured that medicines requiring refrigerated storage had been stored at the correct temperatures to remain effective. Appropriate processes were in place for fridge temperature monitoring daily from 24 February in the upstairs unit, however, on the downstairs unit we saw that although a new process had been introduced from 24 February 2017 the information had only been recorded on 24 and 27 February 2017.

Where people were prescribed medicines to be taken as required, for example for pain, we saw that protocols were in place to ensure care staff administered these consistently in accordance with people's needs.

During our inspection we spoke with a pharmacist from the clinical commissioning group that had carried out an audit the week before our inspection. We were informed that they had found similar issues and the pharmacist supplying medicines had also raised some of these issues during their visits. We saw that the provider had carried out some audits and had also found some medicines administration errors but actions had not ensured that improvements were made and maintained.

People and their relatives told us that they felt that there were usually sufficient staff available to meet their needs although some people told us that they were always busy. One person told, "There are enough staff." A relative told us, "There do seem to be enough staff but they are sometimes not in the room with the residents." Staff spoken with told us they felt there were sufficient staff for them to be able to carry out their role however, we saw that at some parts of the day there was only one member of staff in the unit to supervise the people living there because the other staff member was either on a break or carrying out tasks such as putting people's clean laundry in their bedroom. We saw that staff were always busy with tasks." We saw that staff were attentive to people's needs and the number of staff on duty reflected the planned number of staff according to the staff rota however we saw that staff rarely had time to sit and chat with people. We asked the management team how they determined the number of staff that were required. We were told that the registered manager walked the floor on a daily basis and spoke with staff to ensure that needs were being met. We were told the registered manager and deputy manager were available to assist the staff if people's needs increased.

People and their relatives told us they had no concerns regarding people's safety. One person told us, "I do feel safe here and I have no real worries." Another person told us, " I feel more than safe here, you're not on your own here." there is always someone around if you need anything "
A relative told us, "There is always a member of staff around so we feel mom is very safe here." Staff spoken with showed that they had a good understanding of the different types of abuse and the signs they would look for that would suggest that abuse may be happening. Staff told us that they would inform the registered manager or senior care staff if they had concerns and felt confident they would be listened to. Staff told us and training records showed that they had received training in how to safeguard people from abuse. Information we hold about the service showed that where concerns had been identified the registered manager had taken the appropriate action to notify the local authority and care quality

commission (CQC). This meant that the responsible authorities were able to monitor concerns and ensure that the appropriate actions were taken to keep people safe. Staff spoken with and staff records showed that the required employment checks were undertaken before staff were employed. These including a check with the Disclosure and Barring Service (DBS), references from previous employers and identity checks to ensure people were legally able to work. These checks helps employers to make good employment decisions to keep people safe by employing suitable staff to work in caring professions.

Risks associated with people's needs had been assessed and management plans put in place. For example, people's mobility, nutritional needs and health conditions had been assessed. Staff were knowledgeable about how people's risks were managed and able to provide safe care. We saw that staff managed risks well for example, we saw that staff supported people safely to move around the home.

Good

Is the service effective?

Our findings

People told us that they were happy with the care they received and that staff knew how to support them. One person told us, "It's not too bad here. I have no worries. I am well looked after." Another person told us, "They [staff] are absolutely wonderful and I can't fault the staff at all." A third person said, "I feel the staff are qualified in what they do; they must receive training."

Staff were knowledgeable about people's needs and able to tell us how these were managed. Staff told us that they felt supported to carry out their roles through training, supervision and staff meetings. Although we saw that most people's needs were met appropriately and consistently one person's needs were not met in a consistent way. For example, one staff told us that an individual's fluid intake was being restricted as they would drink too much however; another staff member told us that there were no restrictions on their fluid intake. The person's record did not show that there was a need for fluids to be restricted. This meant that this person's needs were not being met in a consistent way. During our inspection the person appeared happy and content.

Staff told us and records confirmed that they received a wide variety of training to equip them [staff] to be able to meet people's needs effectively. Training included first aid, nutrition management and use of equipment such as hoists. One member of staff told us that they had asked for dementia care training because they had not cared for people living with dementia before being employed at Briarscroft. They were able to give us an example of how they had used their training to support people effectively. They told us that they ensured that they curtains were closed before it became dark and that lights were switched on early as some people became anxious as the evenings drew in. Staff told us and records showed that staff had the opportunity to discuss concerns and training needs in meetings with senior staff. Staff were able to discuss issues during staff meetings. Staff told us that they had received induction training into the work they did. This was included completing a period of working alongside experienced staff to build up their skills and knowledge. We saw that an induction booklet was completed to ensure that staff understood the standards they were required to work to. We saw records that showed that staff were being trained in line with the Care Certificate which identifies a set of standards for all care staff to meet.

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 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that some applications for DoLS had been authorised and some were awaiting authorisation. We saw that some people who were unable to make decisions for themselves were being given their medicines disguised in food. We saw that best interests decisions had been made in consultation with the appropriate people. Staff were aware of who these people were.

We checked whether the service was working within the principles of the MCA. One person told us, "I am normally last to go to bed at around midnight and I often sit chatting to the staff. I can come and go as I please." We saw that staff gained consent and gave people choices during the day. Staff spoken with were aware of how to gain consent. For example, a staff member told us how they would encourage a person living with dementia to get ready for bed. The staff said, "When getting a person ready for bed, I would suggest we go for a walk and when we were passing their [person's] bedroom I would point it out to them and suggest we go in. I would then show them their night clothes and ask if they wanted to get changed. They usually say yes but if they didn't want to I would leave it and try again later." We saw that people were given choices during the day of where to sit, whether to get involved in activities and what they ate.

People told us that they were happy with the meals they ate. One person told us, "The food is ok and I get a choice. The chef will do anything you want really." Another person said, ""It's not too bad food wise. I enjoy it." A relative said, "The only thing is that the meal sizes are a bit small, particularly for the men. It's not enough for them." We observed that the meals were all the same size and where people had eaten all their meal on one unit people were not asked if they wanted any more food whilst on other units people were offered more. We saw that the midday meal was not well presented but people enjoyed their meals. We saw that for one person who had been out with their family their meal had been kept aside to eat when they returned. We saw that people's weights were being monitored on a monthly basis to ensure they were not losing weight. People losing weight or at risk of not eating enough were referred to the appropriate medical professionals for support and advice. We saw that drinks were offered at regular intervals during the day and there were some drinks left on the table for people to help themselves. We saw that on one unit where people were less able to get drinks for themselves the drinks were not offered to anyone during the morning. A relative told us, "I am confident in the care but I do notice that sometimes drinks aren't put out by some staff. I was making a drink and some residents were asking me to do one for them but despite the two care staff I mentioned before being in the room they just ignored their requests and told them to sit down! They didn't get a drink." During our inspection we saw that people received drinks when they requested one.

People told us that their health needs were met. One person said, "They give me my medication every day, the Optician and Chiropodist come in fairly regular so I get all the treatment I need here." During our inspection we saw that a nurse was visiting people that needed dressings and had ordered equipment that was required to help people maintain their skin in good condition. Records showed that people's health needs were being met because they were able to see the GP if they felt unwell and referral to other health care professionals such as dentists, district nurses and through attendance at hospital appointments for follow up of specific health conditions. We were told that families generally supported people to hospital appointments.

Good

Is the service caring?

Our findings

People told us that were happy with the care they received and were very complimentary about the staff. One person told us, "The staff are fantastic."

We saw that people were treated with respect and dignity. One person told us, "Whatever I ask for at whatever time of day I can have. I am absolutely treated with respect and I do feel that they know me." Another person told us, "They are absolutely wonderful and I can't fault the staff at all. I have never seen any rudeness towards residents. They let me do what I want and they always find time to chat to me." Another person said, "Staff assist me when I have a shower they [staff] are very good and respect my dignity." A relative told us, "The staff are caring and kind in general. They comfort residents and show genuine concern for them if they are distressed. They seem to know the residents and they make time to chat with them. They seem to be happy and cheerful staff."

During our inspection we saw many instances of kind and caring interactions with people. For example, we saw one member of staff receive a kiss from a person and in return the member of staff hugged the individual. Staff spoken with were knowledgeable about people's needs and their personal history so that they could react appropriately. For example, staff told us that one person used to work in a pub and sometimes he would become disturbed at mealtimes so the staff always reassured them that they would deal with the situation and this helped the person to settle. At lunchtime one person had a coughing attack. This persisted for some time and the member of staff attended to the person reassuring them with an arm around them and assisting with tissues and drinks. The interactions were skilled and compassionate.

People told us that they were involved in their care and supported to make choices. People told us there were no rules about when they had to get up or go to bed and were able to choose if they took part in arranged activities or not. We saw that people were able to make choices about where they sat during the day and how they spent their days. We saw that people were supported to maintain relationships and friendships that were important to them. For example, we saw two people living in the home holding hands and walking around chatting with each other and families visiting throughout the day.

People were supported to maintain their independence where possible. We saw that people had equipment such as walking aids within reach. Bedrooms had en suite facilities so that people had each access to the toilet and walk in showers. Staff spoken with told us that they encouraged people to do as much personal care as possible and supported them where they couldn't do this themselves. A member of staff told us, "I know it can be embarrassing have a younger person assisting them so I try and to keep chatting to them about things so that we are not focussing on the washing or whatever it is we are doing." This showed that staff had an understanding of how people may feel when dealing with private and intimate tasks. There was a kitchenette area attached to the lounges. A staff member told us, "Where it is safe to do so we promote their [people's] independence but most people need help or supervision to do a hot drink."

We saw that people looked well dressed and cared for. One person said, "I go to the hairdressers every week. I like to keep myself looking nice. " People were dressed in clothes that reflected their likes and dislikes and

their gender. We saw that some people were being supported to have their nails manicured and painted with nail varnish. One person showed us their nails with pride and we heard another person ask the staff member if they would do their nails next to which the staff agreed.

Staff were knowledgeable about people's individual needs and able to ensure that their individual human rights were observed. For example, a member of staff was able to tell us that because one person's religious beliefs they were not allowed caffeine, however, they did have an occasional cup of tea because it was their personal choice." This showed that staff promoted individual choices where people expressed a choice.

People lived in an environment that was clean, comfortable and well maintained. The maintenance person was visible throughout our inspection dealing with issues such as blown light bulbs. There were suitable and varied places for people to sit. The lounge areas provided areas where televisions and music were available but there were also additional quiet areas that people could choose to sit in.

Good

Is the service responsive?

Our findings

People told us that before they moved into the home they were involved in an assessment so that the provider was able to assess whether their needs could be met in the home. We saw that these assessments covered a variety of areas of need including mobility, nutrition and specific medical conditions people had. We received a variety of comments from people about whether they had been involved in reviews of their care but people were happy that their needs were being met.

Most people we spoke with were unsure about whether they had seen their care plans. One visitor told us, "I haven't been involved in [person's] care plan and there have been no reviews." Another relative told us, "I haven't been asked for any feedback and haven't been involved in care planning. I get no input or progress updates at all. "Another visited told us that when they discussed things with the registered manager they went through the care plan with them. Care records we looked at showed that staff reviewed care plans on a monthly basis but there was no evidence to show that the person or their relatives had been involved in their reviews. We asked the provider about reviews and involvement of people and they told us that the review forms were kept in a separate folder. We did not see this folder during our inspection so we are unable to comment on how many people and relatives had been involved in reviews.

People told us that they were able to join in with activities if they wanted. One person told us, I really don't have too many hobbies. I like reading and card games. They [staff] do try to encourage you to join in." Another person said, "There is plenty to do. I like to watch the boxing and football on the TV which I can do. I go out with my daughter but we don't go on trips from here." A visitor told us, "[Person} does get bored at times. They don't go out anywhere. There is one lady who loves to dance and they don't encourage her to do so" During our visit we saw that there were several activities that people could get involved in. We saw that people were taken to other units if they wanted to go to other units so that they could be involved in more activities. For people who didn't want to get involved in group activities we saw that there were individualised activities such as nail painting. One person said, "I like to spend time in the garden pottering about. I tend to not join in with things but I do honestly think that the staff are fantastic." Staff told us that they involved people in daily tasks such as clearing the table if people wanted and encouraged people to make drinks with support from staff. There was a box of socks that people could sit and pair up if they wanted so that they felt they were involved in meaningful tasks. Staff told us that there was an activities person employed whose sole role was to organise activities. The activities person was not available on the day of the inspection. However, the activities witnessed were extremely effective and were enjoyed by people.

We saw that staff were responsive to people's needs. People told us that if they used the emergency buzzer staff attended to them quickly and they didn't have to wait too long for assistance. We saw that staff intervened appropriately when one person started to become angry when another person kept tapping them with their walking stick. This showed that staff remained alert to potential situations arising and intervened to prevent them escalating.

We saw that there were systems in place to gather the views of people. There was a complaints process in place and most people and relatives told us there were happy with the service and had no concerns. People told us that they knew who to speak with but they didn't have any complaints about the service. One person told us, "I could talk to someone if I did have any concerns." One relative told us, "I did have concerns about [person] not being bathed or showered. We had to ask them over and over and I still ended up showering [person] myself. It has only changed now as he can no longer do it himself. Another relative said, "We've never complained and have no concerns." Others ways of gathering people's views included meetings for people and surveys that were carried out on a yearly basis. The results of these surveys showed that people were generally happy with the service they received.

Requires Improvement

Is the service well-led?

Our findings

At the time of our last inspection we found that improvements were needed in the way the home was being managed to ensure the safety of people. At this inspection we saw that some improvements had been made however, further improvements were needed in some aspects of service provision. It was concerning to note that although training, competency assessments and audits were being carried out in respect of the management of medicines people continued to not always receive their medicines as prescribed. This showed that the systems in place to improve this aspect of the service were not sufficient to achieve and sustain the required outcomes. Following this inspection we received an action plan based on our feedback at the end of the inpection to ensure that the issues identified in our inspection were addressed.

We saw there were some audits that were carried out by the registered manager and by managers from the senior management team. We saw that some of these audits had identified issues such as a high number of falls and plans had been put in place to do a closer investigation to determine the causes of the high number of recorded falls. This investigation had looked at the causes of the increased number of falls. Areas looked at included the increased number of infections, staffing levels and staff training in the prevention of falls. The investigation showed that the increased number of infections was due to the weather and that there was a low take up of falls prevention training by staff. The provider told us they were taking steps to ensure that staff completed training in the prevention of falls so that staff had the knowledge they needed to minimise the risks of falls.

We saw that some aspects of the service needed closer monitoring and better leadership. For example, during our inspection we heard that some pressure relieving equipment, ordered by a community healthcare professional had not arrived at the home. The equipment had been ordered several weeks earlier however, the staff in the home had not followed up with the healthcare professional that the equipment had not been delivered so that they [healthcare professional] could follow up on this issue. The equipment was delivered during our inspection but there had been a delay in getting the equipment so that all the necessary steps had not been taken to minimise further skin injury. This was an example of where a well led organisations would have monitored this situation and liaised with other services to ensure the needs of people were met appropriately

People told us that they were happy with the service they received and the management of the home. One person told us, "Everything seems to be looked after properly and things are organised; they do tell you what's going on." A relative told us, "Fantastic place; would recommend it to anyone." We observed that there was a nice, calm, comfortable atmosphere in the home where staff appeared to enjoy working there reflecting in the easy and efficient teamwork we observed.

There was a registered manager in post. 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.
Most people said they knew who the registered manager was and found her to be approachable. One

person said, "The manager is nice. You can talk to her." One relative said, "Management is so well led. Rubina [registered manager] knows all the residents' names." Another relative said, "I know the manager, she keeps me well informed and I can knock on her door at any time. I am totally satisfied with the home and I really couldn't recommend them highly enough." A third relative said, "I know who the manager is but I don't see much of her. She will always say hello if you pass her but she doesn't come to talk to us." Staff told us they felt supported and enjoyed working in the home. A staff member told us, "It is like a second home to me here and also a second family. We are here 12 hours for our shift which benefits the residents and I love it." Staff told us that they felt there was an open culture in the home where their views would be listened to and acted on. For example, staff told us that they could request additional training and support if needed.

We saw that the registered manager was meeting the requirements of the duty of candour. This meant that staff were open with relatives and other professionals about occurrences in the home. We were shown evidence that where people had had a fall relatives were kept informed and notifications were sent to the care quality commission as required by regulations.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always receiving their medicines as prescribed.

The enforcement action we took:

We have issued a warning notice to ensure that the registered provider takes the appropriate actions to ensure that people receive their medicines as prescribed.