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

Summary of findings

Overall summary

The home was visited on the 21 July and 8 August 2016 by an inspector but due to unforeseen circumstances a report of this visit was not completed so another inspection was arranged. Our inspection took place on 3 and 4 October 2016 and was unannounced. At our last inspection of the service on 28 July 2014, the provider was found to be meeting legal requirements in the areas inspected.

Briarscroft Residential Care Home is registered to provide accommodation and personal care to a maximum of 66 older people who may have a diagnosis of Dementia. At the time of our inspection there were 61 people living at the home across four 'units'; Fisher, Spitfire, Dunlop and Digbeth.

There was a registered manager in post who was present during the 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.

Medication was not always given in a safe way by staff. Records kept on medication given did not show that medications had been given as prescribed. Where people had medication given with food, there was no evidence that authorisation to do this had been sought from the GP. This is a breach of Regulation 12 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 end of the full version of the report.

Staff had undergone checks prior to starting work to ensure they were safe to work but there were not always sufficient numbers of staff available to support people Staff did not always manage risks to keep people safe. Staff understood how to safeguard people from abuse.

Staff sought people's consent prior to providing support in line with Mental Capacity Act 2005 but the provider was not always able to evidence that people were supported in line with this where they lacked capacity to make certain decisions. People's experience of mealtimes varied and there was a risk that people's dietary needs would not be met. People were supported to access healthcare services when required but concerns were not always followed up in a timely way. Staff had access to an induction and training to support them in their role.

People were not always supported to make choice or treated with dignity. People were supported to maintain their independence and relationships with family. People had access to advocacy services where required.

People were involved in an initial assessment of their needs. However people were not involved in reviews of their care and records were not always kept up to date. Staff knowledge of people's care needs varied. There were activities available for people and complaints were investigated by the registered manager.

People knew who the registered manager was and felt able to approach them if needed. Audits were completed to monitor the quality of the service but this was not always effective in identifying areas for improvement. People were able to provide feedback on their experience of the service but we could not evidence that responses given were acted upon.

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 receive their medication in a safe way and records kept did not show people had received their medication as prescribed.

Staff did not consistently manage risks to keep people safe.

Staff had undergone checks prior to starting work to ensure they were suitable for employment but there were not always sufficient numbers of staff available for people.

Is the service effective?

Requires Improvement

The service was not always effective.

People's consent was sought in line with Mental Capacity Act 2005 but where people lacked capacity to make certain decisions, the correct procedures had not been followed.

People were at risk of not having their dietary needs met as information held on people's needs were not accurate.

People had access to healthcare services but action to address health concerns was not always taken in a timely way.

Staff received induction and training relevant to their role.

Is the service caring?

Requires Improvement

The service was not always caring.

People were supported by staff that did not always ensure they were supported to make choices.

People were supported to maintain their independence and relationships with family and friends.

People had access to advocacy services where required.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not involved in reviews of their care and staff did not always know the needs of the people they were supporting.

There were activities available for people but these varied on each unit.

Complaints were investigated by the registered manager.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits completed to monitor the quality of the service did not always identify issues and action was not always taken in a timely way where issues were identified.

People were able to provide feedback on their experience of the service but we could not see where suggestions made were acted upon.

People and staff knew who the registered manager was and felt comfortable in approaching them for support.

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection took place on 3 and 4 October 2016 and was unannounced. The inspection was carried out by two inspectors.

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 reviewed the information we held about by home including notifications sent to us by the provider. Notifications are forms that the provider is required by law to send us about incidents that occur at the home. We also approached the local authority for this service to obtain their views.

We spoke with 11 people, two relatives and two visiting health professionals. We also spoke with five members of care staff, two kitchen assistants, the registered manager and the regional manager. As some people were unable to tell us their views of the service, we used a 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 looked at five people's care records, medication records for nine people, staff recruitment and training files, records kept on accidents, incidents and complaints and audits completed to monitor the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People told us that staff would support them with their medication if required. One person told us, "They [staff] do help me with my medication and I think they do this on time". Another person said, "They [staff] support me with my medication. I wouldn't like to be responsible for that myself". Staff we spoke with told us they had received training in how to give medication and that they were observed doing this to ensure they remained competent. Records we looked at showed that this was the case. However, we observed staff giving people medication in ways that were not safe. We saw that when staff giving medication went into a person's bedroom, they left the medication cabinet open in the hallway. This meant that people walking past many of whom have dementia and memory loss could gain access to the medications held in the cabinet. We also observed that staff did not always stay with people while they took their medication so that staff could not be sure that the person had taken the medication given to them. It is of concern that at the inspection of April 2014 people told us that their medicines were left in front of them, which suggest that this poor practice has become custom and practice.

We looked at the records held on medication and found that accurate records were not always maintained. Where people had medication prescribed that needed to be applied to certain areas of the body, body maps had not been consistently completed to ensure that staff continued to apply the medication on the correct area. We looked at Medication Administration Records (MAR) and saw that the amount of tablets recorded on a person's MAR did not always match the amount of tablets available. This meant it was unclear if medication had been given as prescribed. We asked staff about this who could not account for where the errors in these medications had occurred. For some medications, the amount of medication available was not always recorded, so that the provider was unable to determine if they had been given as prescribed.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We saw that although staff could identify risks posed to people, they did not always support them to manage these in a safe way. For example, we saw that one person had a health condition that was causing them discomfort. This would result in the person behaving in a way that could cause them harm. Staff were aware of how this person could be supported with this but we observed that when the person became upset and expressed pain, staff did not take timely action to support the person to alleviate their symptoms and prevent them acting in a way that could cause further injury. This led to the person becoming increasingly distressed. We addressed this with the registered manager who spoke to staff and reminded them of the need to respond to this person as soon as they express discomfort to ensure that their behaviour does not escalate and result in further harm. The provider told us in their Provider Information Return (PIR) that risk assessments were completed and held with people's care records and we saw this was the case. However, records kept on risks to people did not consistently identify what risks were posed and how these should be managed. For example, for one person who would often refuse support that could help them manage risks, there was no guidance in place informing staff of how the risk would present and how this should be managed if the person refuses support. The information we saw about this risk conflicted with the information staff told us about the person and the risk posed. This meant there was a risk of people not

being supported in a consistent way as the guidance available to staff on how to manage the risk was not clear.

Some people we spoke with felt there were enough staff on duty to meet their needs. One person told us, "There is always staff around" and another person said, "Staff are around if I want them". However other people felt that there were not enough staff and that when they required support, this was not always provided in a timely way. One person told us, "There is staff around if you are prepared to wait; there can be a long wait". Another person said, "There is never enough staff". Staff we spoke with felt rushed at times and did not feel that the levels of staff on duty were sufficient. One member of staff told us, "No, there isn't enough staff. I don't rush my jobs but I am always on the go and don't get a break. I feel bad because it means I can't spend time with people". Another member of staff told us how they had at times been left as the only member of staff on a unit with up to 16 people. The staff member said, "I manage by trying to get everything done before the other staff leave but if I can't then people have to be left". We saw that there were sufficient numbers of staff available at times and that where staff were visible on a unit, people had their care needs met in a timely way. However as staff were often busy supporting people in other areas of the home, it meant that people in communal areas did not always have access to staff support. We saw that people within the communal areas often went extended periods without any staff present to support them if needed. We also saw occasions where only one member of staff was available on a unit to meet the needs of up to16 people. We spoke to the registered manager about this who told us that they based their staffing levels on the needs of the people living at the home but were not able to show us a completed record of this.

People told us that they felt safe at the home. One person told us, "I am still finding my way around but I do feel safe". Another person said, "I feel safe, I am fine". A relative we spoke with told us, "I feel [my relative] is safe as staff are here 24/7".

Staff we spoke with understood the action they should take if they suspected someone was at risk of abuse. One member of staff told us, "If someone disclosed something to me, I would make sure they were okay, try and get as much information from them and inform my manager, they [the registered manager] should be involved immediately". Staff told us and records confirmed that staff had received training in how to safeguard people from abuse. We saw that where concerns of a safeguarding nature had been identified, the registered manager had taken appropriate action to notify the relevant authorities.

We saw that where accidents and incidents occurred, a record was kept of the actions taken to reduce the risk of the accident re-occurring. Actions taken following incidents included ordering the person equipment to support them and referring the person to other health professionals.

Staff told us that prior to starting work, they were required to provide references, a full work history and complete a check with the Disclosure and Barring Service (DBS). The DBS would show if someone had a criminal record or had been barred from working with adults. Records we looked at confirmed these recruitment checks took place. We saw that where staff had disclosed previous convictions, risk assessments were put into place to ensure that the person was suitable for employment.

Requires Improvement

Is the service effective?

Our findings

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 checked whether the service was working within the principles of the MCA. We found that staff awareness of DoLS was inconsistent. Some people living at the home had a DoLS authorisation in place, but not all staff spoken with knew who had these authorisations in place and how they should support people in line with these. Some staff did not have an understanding of what DoLS were.

We saw that while some DoLS applications had been made appropriately, there were occasions where decisions that had the potential to restrict or deprive a person of their liberty had been made without following correct procedure. For example, we saw that one person had their medication discontinued due to ongoing health concerns. The person had been assessed as lacking capacity to make this decision but there was no evidence that there had been a best interest's discussion with the relevant people to ensure that this decision was in the best interests of the person. We saw that other people received their medication covertly. Medication given covertly is hidden in food or drink. However, we saw no records to show that there had been a best interests discussion around this or that these decisions had been reviewed since their implementation to ensure they remain in the person's interests. We spoke with the registered manager and the regional manager about this who told us they had discussed these decisions with health professionals but would look into ensuring that the procedure they followed when decision making is documented in future to evidence that they had met the requirements of MCA.

People told us that staff sought their consent before providing their support. One person said, "If staff want you to do something, they will always ask first". A relative we spoke with told us, "They [staff] do ask for permission. If [person's name] doesn't want to do something, she won't and staff are okay with that". Staff we spoke with told us they always gained consent prior to supporting people and gave examples of how they do this. One member of staff told us, "I gain permission by letting the person know what I am doing step by step. If the person cannot understand me, I will use aids like pictures or gestures". Records we looked at confirmed that staff had received training in MCA.

People we spoke with gave mixed reviews about the food they were provided with. One person told us, "I find the food really good. I enjoy it". Another person said, "The food is lovely". However, others did not speak so positively about meals and one person told us, "They [staff] serve me what they like and if it's not up to much, I just leave it". We spoke with staff in the kitchen about how they ensured people's dietary requirements were met. The staff told us that each person had a dietary form that kitchen staff could access to find out people's needs. Any updates to this were then recorded on a noticeboard within the kitchen. We

saw that these systems were in place. However, the information held by kitchen staff had not always been kept up to date. We saw that one person had been losing weight over a period of time. The kitchen staff were required to adapt the person's meals to support them in addressing the weight loss. However, the person's notes within the kitchen did not specify this need. This meant there was a risk that the person would not receive meals to support their weight gain as the information provided to kitchen staff had not been kept accurate. We spoke with the regional manager about this who was aware that the information was not up to date but believed that staff had rectified this issue.

We saw that people's lunchtime experience varied. On Dunlop unit we saw that there was a relaxed atmosphere where staff took time to speak with people and encourage people to eat. People responded well to this and were seen enjoying their meal and joking with staff. However, this was not the case on other units and we saw that on Fisher unit, staff had little interaction with people over lunch and people mainly sat quietly while eating.

People told us that staff would support them to access healthcare if required. One person told us, "I haven't needed a doctor yet but I wouldn't be afraid to ask if I wanted one and staff would help". The provider told us in their Provider Information Return (PIR) that people received regular visits from both district nurses and the GP and we saw this happen and that people had nurses visit them if needed. Records we looked at showed that people were supported to access healthcare support where the need was identified. However, we could not evidence that this action had been taken in a timely way for some people. For example, we saw that one person had recently been to hospital where professionals had recommended that the staff refer the person back to their GP to investigate two possible new health conditions. We could not see from the person's records that this had been actioned. We spoke with the registered manager who confirmed that one of the health concerns had been addressed with the GP but that this had not been recorded. The registered manager confirmed that the second health condition had not been referred to the GP as advised. This meant that the provider had not taken the appropriate action to ensure the person's healthcare needs had been met by ensuring that medical conditions are identified and treated in a timely way.

People told us they felt staff had the skills and knowledge needed to support them effectively. One person told us, "The majority of the carers are good. Younger ones not so but they do their best. If they are not sure, they will ask the experienced staff".

Staff told us that prior to starting work, they had been required to complete an induction that included completing training and shadowing a more experienced member of staff. One member of staff told us, "Before I was allowed to do anything, I had a full building tour and went through the fire evacuation plan. I didn't do any moving and handling, just observing and helping at mealtimes and getting to know people". Records we looked at showed that new staff received an induction and were also enrolled on the Care Certificate. The Care Certificate is an identified set of standards that care workers must adhere too. Staff told us that the induction was useful but that it did not always fully equip them for the role. One member of staff told us, "The induction gave me what I needed to work on one unit [where I had shadowed] but I felt a bit thrown in the deep end having to work on other units". Another member of staff said, "My induction was too brief".

Staff told us they had access to ongoing training to support them in their role. One member of staff told us, "We do get training and it does help me [to support people]". We saw that in addition to their basic care training, staff were provided with training specific to the needs of the people they support. For example, training had been provided in areas such as Dementia and End of Life. Records we looked at confirmed that staff had received training relevant to their role.

Staff we spoke with said they had received supervisions with their manager to discuss their role and identify any training needs but that this is not done consistently. One member of staff told us, "We occasionally get supervision, I have only had a formal supervision once but I do get asked if I am ok". Another member of staff said, "I have not had supervision as of yet but [registered manager's name] has checked that I am ok". Staff we spoke with did feel comfortable in approaching the registered manager and requesting further training if they felt they needed this.

Requires Improvement

Is the service caring?

Our findings

People told us they were involved and given choices about their care. People told us that they chose what time they got up each day, what they would like to wear and what they would like to do. One person told us, "Yesterday, they [staff] came and asked if I wanted to go to the party [but I didn't]". Staff told us they involved people in their care by speaking with them. One member of staff told us, "I will always ask people if they need assistance before providing this". Another member of staff told us how they ensure they ask in what order people like to do things to involve them. The staff member said, "I will ask if they wish to have a shave before their shower or what clothes they would like to wear. Everyone deserves that choice". We saw staff offer choices throughout the day. For example, we saw that staff offered people the chance to attend activities taking place on other units around the home. However, on Fisher unit during mealtime, we observed that staff did not take time to speak with people on an individual basis and instead gave people choices by shouting the options to everyone across the dining room. We saw that this was not effective in giving people choice as many did not acknowledge the staff member or respond to the question. The staff member did not then take the time to speak with people individually, which meant people had missed the opportunity to request further food or make a choice .

People felt treated with dignity by staff. One person told us, "They [staff] are respectful". Staff could explain how they ensured people were treated with dignity and gave examples that included; covering people up during personal care, knocking people's doors before entering their room and giving people privacy when they request this. We saw staff promoting people's dignity. We saw that staff spoke to people in a respectful way and ensured their privacy when providing support in people's rooms. However, we saw occasions where people were not treated in a dignified way by staff. For example, people were not spoken to on an individual basis during mealtimes. We also saw that where one person was becoming distressed with a visible health condition, staff did not support them to have privacy during this time and instead the person was left within the communal areas.

People told us that staff were kind and caring in their approach. One person told us, "The staff are nice". Another person said, "Staff are kind, I always feel at home with them, they are very nice". Staff spoken with displayed warmth when discussing the people they support. One member of staff told us, "I try to do my best for people. This is where I want to be, making people happy". We saw that staff had friendly relationships with people and people were relaxed in their company.

People were supported to maintain relationships with family and friends where possible. People told us that there were no restrictions on when their family could visit. One person said, " My family come and visit, they can come anytime". This was confirmed by relatives. We saw people being visited by family and staff supported them to have privacy if requested. We saw that staff had supported a person to use their mobile phone to keep in touch with their family. Relatives we spoke with told us they felt involved and that staff kept them informed about their family member's well-being. One relative told us, "They [staff] call and let us know of any changes".

We saw that people were supported to maintain their independence if possible. We saw that where people

could walk with the support of a frame, staff encouraged them to do this independently. One person told us how they would go for a walk around the garden independently and enjoyed doing this. We saw other staff encourage people to eat independently where possible.

The registered manager told us that there were people who currently used advocacy services. These had been sourced by the local authority where people required support to make their wishes known and had no family or friends to support. The registered manager understood when advocacy services would be required and how she could access this service for people.

Requires Improvement

Is the service responsive?

Our findings

Prior to moving into the home, people took part in an assessment with the provider to ensure their needs could be met. This was confirmed by a relative who told us, "We had an assessment when [person's name] moved in". Records we looked showed that these assessments addressed areas such as the person's mobility, personal care needs and risk of developing pressure areas. We saw that people who were able, had signed their care record to agree with its content upon moving into the home.

Care records were reviewed every month by staff but we could not see evidence that people were involved in reviews. People we spoke with were unsure if they had been involved in reviews of their care although one person told us, "They get a bit of information about you before you come in but don't really ask afterwards". Staff we spoke with told us that while they would like to involve people, they had not always been able to do so. One member of staff told us, "I don't think people get involved [in their care record]. People are asleep most of the time and I don't want to wake them". Another member of staff told us they try to involve relatives if possible but did not feel this happened consistently. Records we looked at did not show how people were involved in reviews of their care.

We saw that although people's care needs were reviewed, the information held in their care records were not always kept up to date. We saw that one person had an ongoing health concern. Staff we spoke with knew about this but records held did not give consistent information about the person's needs and we found that some information regarding updates from health professionals had not been reflected in the person's record. As these updates were not recorded, staff could not ensure they were supporting the person effectively to manage their health condition and we saw the person become distressed about this. Where other changes had been made to people's care, the records did not always document why the change was required. For example, one person had their nutritional risk score increased at a review. This meant that the person would require changes to how they were supported in this area. Staff we spoke with were aware of the changes to the person's needs, however, the records did not make clear why the person was now at increased risk.

Staff did not always know people and their needs. One person told us, "Most of them [staff] remember my name now; I don't think they know much about me". We found that a number of staff did not know the names of the people they were supporting. We spoke with staff about this who told us this was due to recent changes where staff were now required to work in all four units of the home rather than on specific units. Staff felt that this had meant they did not always know the people they were supporting. Our observations confirmed this. We saw that while some staff who were working with people they were familiar with displayed a good understanding of people's needs, other staff had inconsistent knowledge about the people they were supporting and could not always tell us about people's needs and preferences with regards to their care. We spoke with the registered manager about this who informed us that there was a high proportion of newly recruited staff on duty and that this is why they may not know people well.

People told us that activities were available for them. One person told us, "We had a 'silver day' yesterday, it was good. They had a group in and they [other people] were all dancing". Another person told us about a

trip they had taken to the safari park and how they had a good time there. There was an activity co-ordinator in post that spent time going around each unit of the home implementing activities for people. We saw that there were ongoing activities available for people but these varied between each unit depending on staff availability. For example, we saw that on Spitfire unit, there were activities available for people throughout the day. A local nursery had visited to play games with people and once this was over, we saw that staff spent time completing other activities with people including dancing to music and playing dominoes. However, on Fisher unit, where people had chosen not to go onto the other unit to meet the nursery children, we saw that there were no activities and people spent long periods of time sleeping. We saw that staff did not spend time with people on this unit doing activities that people would enjoy and were often not available in the communal areas for people. Records we looked at showed that people had been consulted on the activities they enjoyed and their interests and hobbies had been documented.

People told us they knew how to make a complaint. One person told us, "If you have any complaints then they [staff] will listen to you". A relative said, "They [staff] have gone through how I can complain". We saw that information was displayed informing people of how they could make a complaint if they needed to. We looked at records held on complaints and could see that where issues were raised, these had been investigated by the registered manager or the regional manager and the person making the complaint had been informed of the outcome of the investigation.

Requires Improvement

Is the service well-led?

Our findings

We saw that audits were completed to monitor the quality of the service. The audits were completed by a regional manager and looked at areas including; clinical needs, accidents, care plans and the completion of observations around the home. We saw that where areas for improvement were identified, an action plan was implemented to address the issue. However, we saw that the actions within the action plans had not always been completed. For example, we saw that one audit had identified that the information held by kitchen staff about people's dietary needs was not up to date. However, action had not been taken to rectify this and we saw that some information held by the kitchen remained inaccurate. The audits had also failed to identify the issues we found at this inspection. For example, the audits on care plans had not identified that information was not always accurate and that the appropriate processes had not been followed where people lacked capacity to make certain decisions. We saw that medication audits were completed but had not identified the errors we found in the recording and safe administration of medication. We saw that some medications needed to be stored at certain temperatures to maintain their effectiveness. Staff had not consistently monitored the temperature of where the medications were stored to ensure that these were stored correctly. We saw that in the previous 30 days, the temperature had not been checked on 14 occasions but this had not been identified as part of the audits. This meant that the quality assurance systems implemented had not been effective in identifying areas for improvement and ensuring any issues were acted on in a timely way.

We saw that where changes had been made to how the service was managed, this had not been evaluated to ensure that the changes made were of benefit to people. For example, we saw that staff delployment had recently changed so that staff were required to work in all areas of the home rather than on specific units. Staff told us that this had not been effective and we saw that people were being supported by staff who did not always know their names or their care needs. This had not been identified by the provider as an area to be addressed. Following the inspection, the regional manager informed us that as a result of our findings, they would be returning to placing staff on specific units so that they could become familiar with a smaller group of people.

We saw that people were given opportunity to feedback on their experience of the service. This was confirmed by a relative who told us, "There are monthly relatives meetings and she [the registered manager] does notes of the meeting and puts them on the noticeboard. I remember doing a survey but have never seen the results". Records we looked at confirmed that meetings took place with people and relatives. We saw that the results of the most recent survey had been displayed in communal areas for people to see. We saw that responses given to surveys had been analysed but could not see that an action plan had been implemented to address areas for improvement. We spoke with the registered manager about this who informed us that areas for improvement were acted upon but we were unable to see evidence to confirm this.

Staff told us they felt supported by the registered manager. One member of staff told us, "She [the registered manager] would support me if I went to her". Another member of staff said, "She [the registered manager] is

very approachable, she is always walking around and checking that people and staff are fine". All staff we spoke with told us that staff meetings took place in which they could discuss the service with the management and records we looked at confirmed these took place. However, staff that did not attend the meetings, were not always provided with feedback on what was discussed. One member of staff told us, "Someone will tell me what went on [in the meeting] if I am here but if I'm not; I don't get to find out". This was confirmed by another staff member who said, "I haven't been to any staff meetings and it doesn't get fed back to you what happened unless staff tell you". This meant that there was a risk that staff would not receive important updates about changes within the home to ensure they can support people effectively. We saw that minutes of minutes were completed and kept within the office. However, staff told us they had not accessed these. Staff we spoke with told us that there was a manager available via telephone outside of office hours if they required support.

People told us they knew who the registered manager was. One person told us, "She [the registered manager] seems very pleasant and listens to you and talks to you". Another person said, "Yes, I do know who the manager is but I haven't had much to do with her". We saw that the registered manager had a visible presence around the home. We saw that she took time to speak with people and that people were relaxed in her company.

We saw evidence of an open culture at the service. Staff we spoke with felt able to raise concerns with the registered manager but understood how they could whistle blow if needed. Whistleblowing is where an employee reports concerns about a provider. One member of staff told us, "If I didn't feel that the provider would do anything [about my concern] I would go to Care Quality Commission". We saw that the registered manager understood their legal obligation to notify us of events that occur at the service and that these notifications had been sent in appropriately. Notifications allow us to see how the provider responded to incidents and concerns raised at the service.

We asked the provider to complete 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. The provider had completed and returned their PIR to us within the timescale we gave and we saw that the information they had provided was accurate.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that medications were managed in a safe way.