Gracewell Healthcare Limited

Gracewell of Salisbury

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Gracewell of Salisbury is a purpose-built care home with nursing for up to 63 people, some of whom may be living with dementia. The service also provided care for people staying short term for example, people who were having rehabilitation following an operation. At the time of this inspection 46 people were using the service. The inspection took place on 23, 24 and 25 August 2016. This was an unannounced inspection.

We carried out an unannounced comprehensive inspection of this service on 18 March 2016. After that inspection we received concerns in relation to the management of incidents and accidents and medicines. As a result we undertook a focused inspection to look into those concerns. This report covers our findings in relation to those concerns. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Gracewell of Salisbury on our website at www.cqc.org.uk

There was a registered manager in post when we inspected the service. 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. The registered manager was present and approachable throughout our inspection. Staff and people who used the service told us the registered manager was available if they needed to speak with her and had confidence in her abilities to manage the service.

Medicines were not always managed appropriately in the home. This included staff knowledge for medicines taken as required, for thickening fluid and the recording for people who needed their medicines covertly.

The home had sufficient levels of staff in place; however staff were not always deployed in an efficient way to ensure people were kept safe. People we spoke with described the pressure staff were under which led to them experiencing rushed care. Comments included "I am concerned by the staff that are under great pressure, I listen and hear them talking among themselves, nothing indiscrete", "I am not sure if residents understand why they are having to wait, especially after a meal, there is pressure to get everyone back to their rooms and they can't do that".

People had experienced very high numbers of falls within the home. Falls were also not always sufficiently followed up in order for corrective action and risk assessments to be put in place. Monitoring forms and recording following accidents and incidents were not consistently completed which made it hard to ascertain a person's accurate condition. Staff's knowledge about people who had experienced falls or had injuries was not always accurate or effectively communicated within the staff team.

Staff had all received safeguarding training, and were aware of their responsibilities in reporting concerns, and the concerns of those they supported. Staff were able to describe to us the actions they would take if they suspected someone may be at harm of abuse.

Communication and participation in the development of the home was encouraged and feedback was considered and where appropriate acted upon. Relatives were welcomed in the home and involved in their loved one's care.

The registered manager was approachable and available for people to see. People, their relatives and staff felt confident that the home was well managed.

The registered manager had developed organised systems in relation to the management of the home. Quality monitoring checks and analysis of incidents were in place and used to further improve the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Medicines were not always managed safely or stored safely.

Sufficient numbers of staffing were in place however staff were not always deployed efficiently to support people in a timely manner.

Risks to people's personal safety had been assessed; however information recorded after an accident or incident was not always consistent in order to support the person appropriately.

People were protected against the risks of potential abuse by staff who had the knowledge and confidence to identify safeguarding concerns, and acted on these to keep people safe.

The recruitment and selection process for potential employees was thorough, and gave a good insight into the nature of the role.

Is the service well-led?

Good

The service was well-led

People and staff felt able to approach the registered manager and raise any concerns they had. People were confident these would be dealt with appropriately.

The registered manager had developed organised systems in relation to the
management of the home. Quality monitoring checks and analysis of incidents were in place and used to further improve the service.

The views of people about the quality of care were gathered through individual and group meetings and by surveys.

Gracewell of Salisbury

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.

We undertook a responsive inspection of Gracewell of Salisbury on the 23, 24 and 25 August 2016. This inspection was completed due to information received. The service had previously been inspected 18 March 2016. We inspected the service against two of the five questions we ask about the services: is the service safe and well led. This was because the information received only concerned these two areas.

The inspection was carried out by two inspectors and was unannounced. Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with nine people who used the service, the registered manager, the senior director of operations, the regional head of care and nursing and eight staff members. We reviewed a range of records which included quality monitoring documents, medicine administration records and seven people's care plans.

Requires Improvement

Is the service safe?

Our findings

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. We saw one risk assessment for risk of pressure ulcers was detailed and concerns had been followed up including a referral to specialists as required. For example, a pressure ulcer had been identified and the tissue viability nurse informed.

However staff's knowledge about people was not always accurate or effectively communicated between shift handovers. We spoke with nursing staff about one person who had a pressure ulcer and they were unaware of this. The staff member had attended a handover prior to starting their shift, but this information had not been passed on. This meant the nursing staff responsible for that floor and people's care, did not have the appropriate knowledge of people's conditions in order to support them effectively.

Information written on the handover sheets and information recorded in people's care plans did not always match up and we saw several inconsistency's which made it hard to ascertain a person's accurate condition. For example for one person it had been recorded in their care plan on 21 August 2016 they had a pressure ulcer grade two. Prior to this the handover sheet stated from 14 August to 20 August 2016 that the person's pressure areas were intact. However on a wound assessment form in their care plan it then stated on 5 August 2016 they had a pressure ulcer on their sacrum, grade two which had been treated between 9 and 24 August inclusive.

For another person it stated on a handover sheet on 24 August 2016 that this person's pressure areas were not intact. The handover sheet for the next day on 25 August 2016 then reported that the person's pressure areas were now intact. Another person had been recorded as having their pressure areas intact; however it later stated on the same day that their wound had been re-dressed. This meant people were at risk from not receiving appropriate care due to poor recording and incorrect information being shared between staff.

We spoke with staff about the accuracy of information in people's care plans and were told "I do the care plans and risk assessments to keep people safe", "Care plans are all up to date, the nurses spend time doing these", "Health professionals come in and the nurse goes around with them, we ask them to write in the care plan about their visit and we pass that on at handover" and "Care plans are up to date but we don't get time to read them, I would like time. We get told what people need". The registered manager told us "Risk assessments are completed by the clinical leads on the floor and reviewed monthly, we ensure on assessment we can meet people's needs and review every month".

People had experienced very high numbers of falls within the home and we spent time looking at how these falls had been recorded and the actions taken in response to these. We did see some elements of good recording especially around photographic evidence and body maps of any injuries noted by staff when people had an accident or incident. Although people had been referred to the GP, falls clinic or had been assessed by a physiotherapist, we found that the recording of accidents and incidents was often inconsistent with corresponding care records. Falls were also not always sufficiently followed up in order for corrective action and risk assessments to be put in place.

For example, during a review of the accidents and incidents forms, we looked at an incident form that had been completed for a person who had fallen during the night and sustained an injury to their foot. However when we looked at the care records for this person, the only information that had been written following this person's fall stated they were fine and had 'appeared to sleep well'. Another incident form detailed the same person having an injury to their head. Although vital signs including their blood pressure, pulse, temperature and respirations had been recorded immediately following the incident, there were no records available to confirm specific observations had been performed as would be required immediately and then for the first few days following a head injury.

For another person an incident form stated they had sustained an injury following a fall however, on an attached form detailing the same incident it stated no injury had been seen. In another person's care file no changes had been made to their falls risk assessment despite this person having falls on 5 and 10 July and 6, 10 and 11 August 2016. The only control measures stated for this person to have their call bell within reach, and supervision with three hourly checks during the day and hourly checks during the night. This had been completed on some of the days; however we found gaps where no observations had been recorded.

One person had experienced a fall on the 22 August 2016. Action taken stated the person had been checked and no injuries noted. Checks were to be completed hourly. However on the handover sheet for staff there was no information recorded that this person had experienced a fall and was to receive regular checks. We saw that an accident form had been completed and mobility care plan and risk assessments. This person had experienced regular falls, seven since May 2016. Six of these falls reported no obvious injuries at the time of incident but had not recorded if any later developed or if the person was checked at a later time. This person was meant to be weighed weekly, as their food intake had decreased and may have been a contributing factor to the increased falls. However we saw this person had only been weighed once in April 2016, a gap of two weeks in July 2016 and in August no weights were recorded.

Another person had fallen 10 times since the end of May 2016 to the date of our inspection. Five of these falls stated there were no apparent injuries at time the person was checked. The care plan detailed this person should be monitored regularly and checks should be made every three hours during the day and hourly during the night. However when we spoke with staff they appeared unclear on how often this person should be checked. One staff member told us this person had to be checked every 15 minutes. Another staff said hourly. A nurse had told us every three hours but then proceeded to say they thought it was more regular now. The care plan and the knowledge staff had did not match up to provide an accurate picture of care.

We asked one nursing staff if they could tell us who was at particular risk of falls and they stated everyone was at risk of falling. This staff member was unable to tell us specific details of people who had been assessed as being at high risk of falls despite working on that floor with people who regularly experienced falls. Staff were able to tell us in detail how they would record a fall for example in an accident or incident form, and any action they would take if someone had fallen, however they were unable to tell us about recent falls people had experienced or if any injuries had been sustained despite it being recorded in people's care plans.

Staff comments included "We have had training in reporting incidents, we press the emergency bell, the nurse would check, an accident report is written by the person first on scene", "We make sure people have the equipment they need, if need bed rails check they are working", "We have risk assessments in place for falls, one person who falls a lot has a sensor mat and crash mat", "Always make sure if someone has an aid they use it, make sure all obstacles in the room are removed, make sure if they wear glasses they have them" and "Nurse writes up incident forms, I ring the assistance bell and wait for the nurse to check over, if ok we get the hoist and help them up. The nurse will call a GP if the person is in pain". One staff member told us

there had been instances where the care staff believed a person should have had further medical help but they were not the ones making the decision to call a GP.

It was hard to establish the exact times and dates of some people's falls and if any injuries had been sustained at the time because the recording was unclear and often conflicted when written in several places. Injuries had previously been noted at the time the person fell and not followed up at a later date. We saw that for people who experienced several falls bruising from a previous fall would often be noticed during this fall and then recorded by staff as being unknown how the person had obtained this.

This was a breach of Regulation 17 (2) (c) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People spoke openly about the falls they had experienced, one person said they had recently slipped out of a wheelchair but nurses came from all directions and checked them. This person also reported being checked the next day. One person told us "I fall over quite a lot and sometimes they see me and sometimes I have to wait but they always respond. When I have fallen four staff responded in few minutes, the nurse checks me over then help me up". Another person told us the home are short staffed especially at weekends. They spoke about a fall they'd had a while ago and had to shout out for help as they were stuck behind the door and it had taken staff some time to come to their assistance. This person did say however they felt safe living in the home further commenting "Staff are not always patient, people are only human and we get used to it over the years, but when I had my fall staff were excellent".

During our inspection we heard the emergency bell going off several times and we saw staff responding to this in a timely manner. People had assessments in their care plans to ensure they were able to press and use the call bell to alert staff they needed help. This had been reviewed regularly. The registered manager explained that a new form had recently been implemented to remind staff of what they already should be doing when a person experiences an accident or incident. This form also included observations to be completed and recorded 24 and 48 hours after a person has fallen.

Medicines were not always managed or administered safely. Some people had been prescribed medicine as required, referred to as 'PRN' medicine. Protocols were in place to monitor when this medicine may be required. One person told us they sometimes need pain relief medicines to help manage their pain saying "Nurses always ask if I would like any pain relief". Another person said "If I'm poorly observations are done and I get pain relieving medicine". A member of staff commented "If someone can't tell us they are in pain, we know people well so we can see. If someone is poorly we get the nurse who does observations and then if no improvement the nurse will call a doctor".

One nurse told us if PRN medicines had been given for more than four days in a row, then the person's GP would be contacted to review their medicine. However, the PRN medicine for one person had been given daily for more than one month, and one nurse was not aware this was to be given as PRN. The nurse had believed it had been written up for regular daily use. When we highlighted this to them, they told us they would contact the person's GP to review this medicine to ensure it was prescribed in line with their needs.

There was limited guidance in the Medication Administration Record's (MAR) on how and where to administer topical ointments and creams. Although topical treatments had been signed for on the MAR when they had been applied and body maps were available for completion with the MAR, these had not been completed to indicate where topical ointments should be applied. We asked one member of staff where they would apply a topical treatment which was prescribed to manage a person's pain, and they told us there was nowhere specific this should be applied but that they would ask the person where they would

like it. However, when we looked at the care records for the same person, there was a body map available in their care plan which indicated it should be applied on their back. As this body map was not available with the MAR, it was not being referred to and staff did not have the correct information to inform them of how to apply this topical medication.

For another person their MAR stated that one tablet was to be taken if their blood pressure measurement was 'OK'. There was no record of daily blood pressure being taken in the MAR and no guidance as to what level their blood pressure should be in order to safely administer this medicine. When we asked the nurse administering the medicines about this, they told us the requirement to take this person's blood pressure prior to administering this medicine had only applied when they first commenced this medicine and was no longer necessary. They also told us the MAR should have been updated to reflect this at the time the blood pressure measurement was no longer required. We asked whether there was still a requirement for this person's blood pressure to be monitored at all whilst on this treatment and were told it should be measured once per month. The care records for this person, confirmed monthly blood pressure recordings had been made however, this information was not available on the MAR and there was no written guidance to inform staff when their medicine could not be taken i.e. depending on their blood pressure measurement. This meant there was a risk this person could be given their medicine when it was not safe to do so.

Staff were able to tell us the requirements and considerations that needed to be made prior to giving medicines covertly (Covert medicine is the administration of any medical treatment in disguised form). They knew about the requirement for making a decision in people's best interests and the need for capacity assessments to be made. Staff told us they would also seek advice from a person's GP and pharmacist for example, when tablets needed to be crushed to determine it was safe to administer them in this way. We looked at the records of two people who were receiving their medicines covertly. One person had clear documentation showing the correct processes had been followed and this included written confirmation from their GP and pharmacist that it was safe to crush their tablets prior to administration.

However, this was not the case for the other person's records and although there was documentation from the person's GP available, there was no written documentation from a pharmacist to confirm it was safe to administer their tablets when crushed and placed in jam. When we asked staff about this, they told us a pharmacist had been consulted but as this had been some time ago, the documentation confirming this had most likely been archived. Staff told us they were unable to locate this documentation but would contact the pharmacist again to obtain this from them. The registered manager was proactive in ensuring this information was obtained and put in place within 24 hours of the inspection and sent confirmation to us that this had been completed.

During our inspection we spoke with people in their bedrooms and in communal areas. Whilst we were speaking with one person a member of staff came into the person's bedroom with a jug of water and proceeded to pour them a glass of water before placing it beside the person. There was a sign clearly displayed in this person's room that indicated they were to have prescribed fluid thickener in all of their drinks. This is given to people who have swallowing difficulties or are at risk of choking. We asked this person if they were meant to have thickener in all of their drinks and they told us that the staff were meant to put it in but had not. The person further said they did not like water so would not drink this anyway. We alerted a nurse that a drink not containing thickener had been given to this person and the nurse immediately went and removed it. If this person had not had capacity to understand they were meant to have thickener they may have drunk this and been placed at risk of choking.

This was a breach of Regulation 12 (2) (g) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We observed a medicines round during the inspection. The nurse explained to people what medicines they were taking and completed the MAR after each person according to the completion requirements. We saw that people's medicine records included information that clearly identified them including a recent photo, clear details of any allergies and special notes on how they should take their medicines and what should be checked prior to their medicines being administered. Staff told us they received regular supervisions to determine competency in medicine administration and one member of staff told us in response to a recent medicines error all nurses had received competency assessments in medicines management.

People we spoke with told us they felt safe living at Gracewell of Salisbury. Comments included "I feel safe, they are very good", "I feel very safe living here", "Staff are alright, it's not bad living here", "I feel safe, no concerns, I would feel happy to go to straight to management" and "I have got a pendant to call for staff if I fall in my room".

Staff had all received safeguarding training, and were aware of their responsibilities in reporting concerns, and the concerns of those they supported. Staff were able to describe to us the actions they would take if they suspected someone may be at harm of abuse. Comments included "I would go to nurse in charge, and if nothing was done go to manager. We have a whistle blowing line and if I wasn't happy I would use it, that's what I'm in this job for", "We have a duty in keeping residents safe, making sure their welfare is cared for in the way we want our family to be looked after", "If I see anyone mistreated I would report it. Report to the nurse or clinical lead and go higher until it was dealt with" and "If there was an incident between two residents, I would intervene and assist, safety is first, then update the care plan, inform family, complete regular checks, inform the manager, complete incident forms and inform safeguarding".

At the time of this inspection there was an on-going safeguarding investigation. The registered manager was in the process of taking action in relation to this. The registered manager told us "When responding to allegations of abuse we make sure the person is safe, start an investigation and do an incident report". The registered manager explained that herself, the deputy manager and the clinical leads were responsible for making any necessary safeguarding referrals to the local authority.

There were sufficient staff to meet people's basic care needs. However staff were not always deployed in an efficient way to ensure people were kept safe. During our inspection we observed that staff were not always visible on the floor for people to speak with if they needed. At times staff could be seen together in groups talking amongst themselves rather than with people living in the home.

People we spoke with consistently described the pressure staff were under which led to them experiencing rushed care. Comments included "There is pressure on staff, they get stressed, with so much to do in little time, they manage wonderfully", "You can always get help but waiting times depend on the pressures on staff, they try, they are getting more staff. I think there is a difference, sometimes it feels like a long time", "I am concerned by the staff that are under great pressure, I listen and hear them talking among themselves, nothing indiscrete", "I am not sure if residents understand why they are having to wait, especially after a meal, there is pressure to get everyone back to their rooms and they can't do that" and "There are not enough staff, they need more in the morning to help them get up. Staffing levels are a bit short".

We spoke to the staff to see if they felt they had enough time to support people safely and they told us "Staffing is a nightmare sometimes if someone goes sick, we are short staffed", "Never enough staff, people are well looked after but it would be nice to spend more time with them", "There's enough staff, little bit rushed, call bells ring and people want to get up" and "We are sometimes short staffed, mostly it's ok".

Staff carried buzzers that alerted them when call bells had been pressed. There were also call bell panels

displayed around the home so you could see in which room or area the call bell had been pressed. People had mixed feelings about the length of time they had to wait for help when using their call bell. One person told us "I have got a call bell to press for the nurse; they don't respond quickly, they have other people to see". Another person said "I have a call bell, I don't wait that long it's quite good". During our inspection one person we spoke with told us they were in the process of making a complaint regarding waiting times for staff. This person said they had been told they were short staffed commenting "I have to wait long times sometimes, there's no point in having a call bell".

We reviewed the previous month's staff rotas and saw there had been sufficient levels of staff working in accordance with the registered manager's dependency tool used to calculate appropriate levels of staff to meet people's level of need. We spoke with the registered manager who agreed that the concerns raised by people may be an issue of finding more efficient ways of working rather than the amount of staff, and informed us this would be looked into. The registered manager further said "We are looking at morning time at the moment as this is a high risk time, if we need to bring in an extra morning member of staff we will".

The registered manager explained there was a robust recruitment process in place and a supervised induction to ensure people were kept safe. This included sourcing two references and a Disclosure and Barring Service checks (DBS). A DBS check helps employers make safer recruitment decisions and prevents unsuitable people working with vulnerable people. The registered manager told us "At the interview process we discuss safeguarding, to get an idea if that knowledge is already there before staff come into the home. We take character into account as well as experience, we want to get the right candidate, we have a low turnover of staff, and have very experienced nurses".

Good

Is the service well-led?

Our findings

The home had a registered manager in place who was present throughout our inspection. People and staff spoke positively about the registered manager being approachable and supportive but some raised comments that they did not see her very often on the floors. Comments from people included "I don't see the manager very often but we are on good terms if I needed too", "I don't get to see them much, it would be nice if they came round more", "The manager doesn't come around very often, she's very nice and I get on with them. If I need to bring something up I will go to her and she says she will address it" and "The manager knows people very well. She comes and goes around the home all the time".

Staff also commented saying "The manager is very supportive. During my induction, I asked for more time to shadow staff before I worked independently and she supported me with this", "The manager I don't see very often, but she has been supportive and approachable", "The manager is not on the floors a lot, but I'm happy to approach management", "I feel supported, I have everything I need to do job properly", "I feel supported, management are very kind" and "The manager is very approachable, any time you call her when she's not in the home she answers. The management is excellent". The registered manager told us she completes daily walk about of all the floors and had an open door policy to anyone wishing to speak with her. During our inspection we saw the registered manager responding to the emergency bell when it sounded.

People were encouraged to contribute to improve the service and were kept informed of events happening in the home. The registered manager told us she regularly received feedback from people and their relatives, and encouraged this with a communication book in the dining room, relative meetings, feedback surveys and a suggestion box. The heads of departments would attend resident and relative meetings so people had the opportunity to address queries with the appropriate person. Minutes from these meetings would be displayed on a noticeboard and emailed to relatives. One person told us "I feel happy to talk to staff". Other comments from people included "It's very person centred, they succeed well in this", "It's a very good home" and "I am happy to raise concerns and when I have it has changed".

During our inspection a new staff open day was being held where potential employees could come and visit the home and chat with people that lived there. The registered manager said people would then feedback to management about what they thought and had the opportunity to be involved in the process of recruitment. One staff member told us "It's a family environment; we have a relationship with the families that come in, if the residents are happy we are happy".

Staff were aware of the accountability within their role and the responsibility they had to protect people living in the home. We saw that where necessary the registered manager had completed investigations into concerns and if required taken further disciplinary action. The registered manager told us "We discuss safeguarding with staff in their supervisions; the quality team come and talk to staff about their knowledge every 16 weeks. At team meetings we discuss any safeguarding concerns with staff, without breaking confidentiality". The registered manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. We saw that people at high risk of falls were recorded every month. This monitoring looked at the times the falls occurred and on which floor the falls took place. This was then cross referenced with any urinary tract infections or chest infections to rule out other potential reasons why a person was experiencing a high number of falls. Audits had been completed for falls, which showed a high number of falls on the nursing floor. In June and July 2016 there had been 14 falls each month. The trends for times had been calculated but these were not significant enough to draw any significant conclusions from.

Each month a percentage was taken at random of people living in the home of any falls they had experienced alongside the high risk people. The registered manager told us from the outcome of this audit they track back to the person's care plan to ensure the appropriate action has been taken and an action plan is in place. This would then be re-audited and evaluated by the registered manager and reviewed by the clinical team who come into the home from head office. The registered manager explained action had been taken in response to the high number of falls which included increasing the staffing on that floor. There was now two nurses and four care staff instead of the previous three.

The home had recently worked on reducing the use of bed rails instead offering other safety measures such as sensor mats, lowering the bed, giving people a pendant alarm to wear, a crash mat on the floor or a commode by the bed overnight. Conversations had taken place with people and their relatives around this and where people preferred to have bed rails in place, their care plans reflected this. The registered manager told us "We are always auditing and updating systems. The risk assessments have recently changed in terms of being clearer, the scoring and what we are looking at"

Medicines were audited monthly and nurses would complete checks on a different floor to their own. Alongside this the medicine administration records would be monitored for any missed signatures. Observations and competencies for staff administering medicines had been completed annually; however this had been brought forward due to an on-going investigation.

The registered manager had recognised shortfalls within the home and implemented new forms in response to this around medicines and observations after accidents or incidents. The forms were in the process of being implemented during our inspection and a meeting had been held with staff to discuss the purpose of these forms. The registered manager explained "It's about being acutely aware of passing things over in handover. It's about checking and rechecking so we know all things have been exhausted". For staff that had responsibility for making any safeguarding referrals discussions had been held so they all were aware of what needed to be referred at any time.

The registered manager told us she felt supported by senior management commenting "We have visits from the care quality team; my line manager would be here any time and the operations director. I have also got a peer group of home managers".

The registered manager reported the home had good links with other healthcare professionals who visited on a regular basis saying "We work well with the tissue viability team, residential nurses and mental health nurses. We work with the pharmacy and dieticians, and have done a lot of work around weight loss. They have come into the home and did training with staff. The Alzheimer's society also use our facilities and do training and staff can attend this"

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 Medicines were not always managed safely. Information relating to people's medicines was not always correctly followed or in place for staff to follow. Regulation 12 (2) (g)

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 Information relating to accidents and incidents and subsequent treatment was not always recorded correctly. This meant people were at risk from not receiving appropriate care due to poor recording and incorrect information being shared between staff. Regulation 17 (2) (c).