

## Fordent Properties Limited

# Orchard Manor Care Home

## Inspection report

Greenacres Court  
Acres Lane  
Upton  
Chester CH2 1LY  
Tel: 01244 376568  
Website: www.example.com

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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?

Good 

Is the service responsive?

Good 

Is the service well-led?

Good 

### Overall summary

We visited this home on 16th and 17th June 2015 and the inspection was unannounced.

The last inspection was carried out in September 2014 and we found that the registered provider was meeting the regulations we assessed.

Orchard Manor is a care home for older people set in large grounds. It is on a bus route from Chester City Centre. There are 90 bedrooms in total divided into five units: Two of the units provide general nursing and personal care and three of the units provide nursing and

personal care for older people with memory impairment. All the rooms are single and most have en-suite facilities. There are also several lounges and dining rooms. At the time of our visit there were 85 people living at the home.

There was a registered manager employed to work in the home. 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

# Summary of findings

service is run. However the registered manager was absent due to maternity leave and a manager from one of the registered provider's other services was overseeing the home.

We found a breach 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.

People told us that they felt safe at the home and that staff understood their care needs. People commented "I am very well looked after", "The staff are wonderful" and "The staff's manner is very kind and caring."

However we identified concerns with the records and administration of medication, which meant that people who used the service may not have received their medication administered as prescribed and this could affect their general health and wellbeing.

The registered provider had systems in place to ensure that people were protected from the risk of potential harm or abuse. Staff had received training and were aware of how to report suspected allegations of abuse. This meant that staff had knowledge and documents available to them to help them understand the risk of potential harm or abuse of people who lived at the home. The registered provider had policies and procedures in place to guide staff in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and staff were aware of how and when best interest decisions needed to be made.

Where possible people, were involved in decisions about their care and support. Staff made appropriate referrals to other professionals and community services, such as GPs, where it had been identified that there were changes in someone's health needs. The staff team understood people's care and support needs, and they were kind and treated people with respect.

Care records contained good information about the support people required and were written in a way that recognised people's needs. Reviews of people's care were completed and up to date.

Good recruitment practices were in place and pre-employment checks were completed prior to a new member of staff working at the home. Training that staff had undertaken was up to date. Staff had the opportunity to discuss their work at staff meetings and during supervision or appraisals.

The home was clean and hygienic. However, people did not have anywhere to store their property securely. Bedroom, bathroom and toilet doors did not have a facility to lock them. On day two of the inspection the registered provider had started to install locks on the bathroom and toilet doors. We saw that units where people were living with dementia had not been adapted to meet their needs. A recommendation was made regarding this. Following the inspection we had confirmation that the bathroom and toilet doors had locks fitted and that locks had been ordered for bedroom doors and these would be fitted as soon as possible.

During our observations across the two days we found that staff were available to help and support people as needed. However, on one occasion people were left unsupervised for about 20 minutes on one unit which meant that there were no staff available should they need help or support. Also this was not in line with the practice of the home to have a staff member available at all times. We made a recommendation regarding this.

People told us they didn't have any complaints about the home. The registered manager had received four complaints since the last inspection. The documentation relating to these showed complaints were dealt with in line with the registered provider's complaints policy. Staff knew what to do if anyone raised an issue or wanted to complain.

The registered provider had a range of quality assurance systems in place. These were completed regularly and when concerns were noted these had been followed up and action noted.

People told us the food was good. We noted some concerns with regard to the temperature of meals on one unit and we discussed this with the manager at the time of the inspection.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not safe.

Doors to bedrooms did not have locks fitted which meant that people did not have a safe facility to lock away their personal items. Bathrooms and toilets did not have locks fitted and therefore the privacy and dignity of people could be compromised by this.

Medication records and administration of medicines were not safe.

Recruitment processes were robust and staff had been checked to ensure they were suitable to work at the home.

Requires improvement



### Is the service effective?

The service was not effective.

Units where people who were living with dementia were not specifically adapted which meant that signs and adaptations were not in place to meet people's needs and promote their independence.

Staff were aware of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity staff were aware of when and how best interest decisions should be made.

There was sufficient staff on duty to meet the needs of people. Staff received supervision and training which was appropriate to their role.

People told us the food was good and they had a choice of meals.

Requires improvement



### Is the service caring?

The service was caring.

People told us they were well cared for and that staff were kind to them. Staff were friendly and supportive to people.

Staff had a good knowledge of the people they supported. They knew people's likes and dislikes and their family history.

Good



### Is the service responsive?

The service was responsive.

A complaints policy was readily available in the hallway and when complaints had been received the registered provider had dealt with them in accordance to their policy.

People told us that staff were responsive to their needs and we saw that people were supported in their own rooms. Care plans were detailed and showed the support people required.

Good



# Summary of findings

## Is the service well-led?

The service was well led.

There was a registered manager in place and people told us she was approachable and would listen to them. Staff told us they were well supported by the management team.

There was a range of quality assurance systems in place which were completed regularly and where concerns were raised these were noted and actioned appropriately.

People who lived at the home and their relatives had the opportunity to discuss issues during meeting which were held regularly. An involvement audit was completed each month which gathered the views of people and their relatives.

Good



# Orchard Manor Care Home

## Detailed findings

### Background to this inspection

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

This inspection took place on 16th and 17th June 2015 and was unannounced on the first day.

We spent time observing care in the communal areas and used the short observational framework (SOFI) as part of this SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at all areas of the building, including people's bedrooms and the communal areas. We also spent time looking at records, which included six people's care records, six staff recruitment files and records relating to the management of the home.

The inspection team consisted of three adult social care inspectors and an expert by experience. An

expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert by experience had knowledge and experience of residential care homes.

Before our inspection, we reviewed all the information we held about the service. This included notifications received from the registered manager and we checked that we had received these in a timely manner. We also looked at safeguarding referrals, complaints and any other information from members of the public. We contacted the local authority safeguarding and contracts teams, infection control team and Healthwatch for their views on the service. The safeguarding team and Healthwatch had no current concerns or information. The contracts team had recently visited and no issues had been raised. The infection control team had visited recently and made some recommendations. The registered manager had put an action plan in place to address the recommendations.

On the two days of our inspection, we spoke with 12 people who lived at Orchard Manor Care Home, the manager, deputy manager and 10 members of the staff team. We also spoke with a visiting professional, a healthcare professional and seven relatives.

# Is the service safe?

## Our findings

People said they were well cared for and felt safe. Comments included “I am safe here” and “Yes, very much so.” One person’s relative said “She feels safe here and we think so to.” However, we went on to ask people about the safety of their personal possessions the responses were much less positive. Several people said items had gone missing from their rooms. A relative told us that “Last Christmas I gave my relative a cardigan but it just disappeared and it was named, it’s mostly clothes but some earrings have gone missing too.” Another person said “Clothes do disappear but they come back eventually, some residents do pick things up but they come back if they are named”. We noted that bedrooms did not have any locks on the doors. We also saw that there was no lockable storage areas within the bedrooms. This meant that people who lived at the service did not have a safe facility to lock away their personal items.

One person told us they had fallen twice, once whilst trying to mobilise alone, and once falling from their wheelchair. We checked their care records in relation to the incidents and found appropriate recording. On one occasion the person had been taken to hospital to be checked, the other incident the person had removed their lap strap in their wheelchair. Records showed that the falls risk assessment and falls scores had been reviewed and updated. We saw that the person had been assessed and supplied with a specific chair that met their needs. This meant that accurate records were kept and changes made when incidents occurred.

We noted that bathrooms and toilets did not have locks fitted which meant that the privacy and dignity of people could be compromised by not having the option of locking the door. The manager was new to the service and had not realised that bedrooms, toilets and bathrooms did not have locks fitted. She said this would be rectified as soon as possible. On the second day of inspection the registered provider had started to put locks on toilet and bathroom doors. Following the inspection we had confirmation that the bathroom and toilet doors had locks fitted and that locks had been ordered for bedroom doors and these would be fitted as soon as possible.

**We recommend that the registered provider ensures that people have facilities to protect their property and maintain their privacy and dignity.**

We looked at administration and records relating to medication and observed three different nurses administering medicines to people. They checked the person against their photo prior to administration and they asked people if they needed PRN (as required) medicines before preparing them. Two nurses administered the medicines before signing the Medication Administration Record (MAR) to record that people had taken them. The other nurse signed the record before taking the medicine to the person. This is unsafe practice because people may not actually take the medicine dispensed and we saw on some MAR sheets that the nurse’s signature had been overwritten to show medication was refused or destroyed.

A nurse on duty offered pain relief medication to one person. We reviewed PRN medicines and noted there were no indications for use apart from the prescription on the MAR. For example, paracetamol four to six hourly for pain. Maximum eight tablets in 24 hours. All PRN medicines were assigned times to be given; 0800, 1400, 1800 and 2200. These medicines should be available as required, not only at specific times. Nurses said they would write a different time into the MAR if this happened. There was no evidence in the MAR to show this had happened. We noted that there were some discrepancies in the amounts of PRN medication that was available to people. We looked at records for six people, three were correct and the other three had discrepancies. This was poor practice and improvements need to be made to achieve accurate recording.

One person had a medicine prescribed with specific instructions from the GP. We asked a nurse what this meant and they said that the person had a fluid intake record chart and they knew when the person had drunk enough, but did not have any particular amount in mind. There was nothing in the care plan or on the fluid intake chart to show what this amount would be. We noticed records showed a variation of amounts of liquid taken over the last week, however, the medicine had always been given.

**We found that the registered person failed to ensure the proper and safe management of medicines. This was a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Medicines were stored securely. All controlled medicines were stored in a downstairs clinic room. The registered provider had an effective system for ordering repeat

## Is the service safe?

prescriptions and newly prescribed medicines to ensure that sufficient quantities of prescribed medicines were available for people. Controlled medicines were stored safely and appropriate records were kept.

MAR sheets contained up to date photographs of the person for whom the medicines were prescribed. We saw that documentation of allergies was not always completed. This meant that people could be allergic to a particular substance which might affect their medication and therefore accurate up to date records should be kept.

We reviewed the staffing levels at the home. We looked at the last four weeks rotas, which showed the staffing levels during this time. During our observations across the two days we found that staff were available to help and support people as needed. However, on one unit where the staffing levels were two carers and either one nurse or an extra carer we found seven people in the lounge and four people in their rooms. No staff were visible, we found that two staff were supporting one person with bathing. We sat in the lounge for about 20 minutes and then staff appeared. This meant that people were potentially put at risk because they were left unsupervised for long periods.

**We recommend that the service looks at the staffing levels and deployment of the staff team to ensure that people who use the service are appropriately supported.**

We spoke with the manager, deputy manager and staff team about safeguarding procedures. Staff described the

different types of abuse and what signs to look for if abuse was suspected. They also told us the right action to take so that people were protected. Staff confirmed they had undertaken adult safeguarding training and we saw from records that this was renewed every two years. This meant that the staff had the knowledge of what to do if they suspected abuse was taking place. We noted that three safeguarding referrals had been made by the registered provider to the local authority and that CQC were promptly notified of these.

Staff recruitment files contained application forms, references, Disclosure and Barring Service checks, health questionnaires and questions and answers from the person's interview. The staff files were well presented and we found that good recruitment processes were in place.

The home was clean and hygienic. We looked at the safety of the home and the maintenance of equipment such as the hoists, passenger lift and fire and call bell system. We saw certificates which showed these areas were up to date and ensured people were living in a well maintained environment. We saw that a number of free standing wardrobes were not fixed to the wall and posed a risk. One in particular we asked the manager to address immediately as the wardrobe was unsteady and the chest of drawers had a sign on them saying they could tip over. The manager actioned this immediately and the maintenance person dealt with the problem on the same day.

# Is the service effective?

## Our findings

People said they had discussed their health care needs as part of the care planning process. One person said “Quite often I need the chiropodist and they are quite quick and when I have needed the doctor, he comes on request and that has been quite quick.” People explained that they would talk to staff if they were in pain or unwell. Within people’s care plans we saw that there was information and guidance on how staff can best support people with their healthcare needs. We saw records had been made of healthcare visits. These included GPs, district nurses, dietician review and chiropodist. Where people had a high risk of malnutrition they had been referred to a GP and reviewed by a dietician. People who had wounds had a care plan and a folder was maintained with details of wound assessments, progress and dressings completed. When dressings were completed by external NHS staff, these were also documented so staff could ensure they were done and knew whether wounds were improving.

People told us they enjoyed the food. Comments included “The food is quite good, I tried it the first day my wife came here and she seems quite pleased with it”, “Very enjoyable”, “What I have seen of the food is quite good, it looks good quality and fresh” and “We choose what we want, it is usually hot and tasty” and “The food could be a bit better, sometimes it is ok and sometimes there is no choice.” We observed lunch on several of the units over the two days. In some units people ate independently in the dining room or lounge areas, and were engaged in conversation throughout the meal. Some people were supported to eat in their rooms and usually one member of staff undertook this role. We saw staff supporting people to eat and found that they were on the whole encouraging, and made every attempt to engage with the individual they were supporting. Food was delivered to the units in a hot trolley, however there were only four trollies for five units which meant that one was shared with another unit and staff and people living on that unit were very unsure when the meal would arrive. The temperature and safe storage of the food provided on both units was not adequate. We found cold food had been left on the table when a fridge was available and the day was particularly warm posing a potential risk. We found that hot food had been removed from the trolley and left on the table covered by a plate, we tested the food

as staff were about to support someone eat it and it was cold. The food was warmed in the microwave but staff could not be confident that it was at the required temperature as no food temperature probe was available.

The chef showed us a copy of the three weekly menus which showed a choice of meals at lunch and dinner times. We saw a temporary menu had been devised for the refurbishment week, when the main kitchen and dining room would be out of action. However, we saw on one unit that the staff were unaware of the changes and were offering people choices that were not available. The chef had copies of people’s likes and dislikes noted. Menu plans in the kitchen did not identify any fortified diets, everyone was listed as “normal diet”. The chef told us that all meals were fortified using cream, milk powders etc. However, not everyone in the home may need a “fortified” diet and this may be too rich for some people.

People said they were well cared for and the staff were good and kind. One person told us that they liked living in the home and that staff helped them a lot. They told us that staff were “great.” Another person said “All the staff are good.” Some people could not tell us if they were involved in decisions about their care. However we saw that people were involved in decision making in many aspects of their daily life. This included being asked what they would like to eat, what clothes they would like to wear and where they would like to sit.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated DoLS with the manager. The MCA 2005 is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people’s best interests. DoLS is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken. One staff member had a clear understanding of mental capacity and deprivation of liberty (DoLS), another staff member was less sure about MCA and DoLS, particularly with regards to people who lacked capacity and had difficulty with communication. People’s mental capacity was assessed and documented in the care plans. This was a general assessment and not related to specific decisions. One assessment stated “Disorientated to time and place and lacks the understanding and the capacity to make decisions.”

## Is the service effective?

However when we asked staff about this person they said the person could make choices about food and drink, clothing and whether to take medicines or not. Three DoLS applications were in place and the Care Quality Commission had been notified of these. We saw details of best interest meetings that were held with families and other health care professionals. One person had a Lasting Power of Attorney (LPA) in place, however the registered provider had only been told of this by relatives. In line with the MCA 2005 the LPA documentation should be seen and copied to ensure that decisions made on behalf of an individual are in line with the LPA application.

We saw that training certificates were in staff files. Training had been completed by staff on health and safety; infection control, food hygiene; first aid; safeguarding adults, fire training and moving and handling. Some staff had undertaken training in care planning and equality and diversity. Nurses who administered medicines said their competency had been checked by the manager when they first started working at the home. Staff received regular supervision and annual appraisals. They had the opportunity to attend staff meetings which were held on a regular basis.

The staff induction programme was discussed with the manager and staff team. Two staff who had started work at the home in the previous year told us they had an

induction and as part of it they had shadowed other more experienced staff. The induction had lasted for a few hours or half a day and included practical training about moving and handling people, general health and safety, infection control and safeguarding. We were shown the new induction training plan and record which detailed the areas to be covered to ensure staff knew about the service and what was expected from them. The induction checklist was signed and dated by the employee and line manager. The employee handbook covered all areas of the staff role and disciplinary and grievance procedures. Staff signed to show they had received a copy and this was seen on staff files.

We saw that three units provided support for people living with dementia. However, the environment had not been designed specifically for people living with dementia. Bedroom doors did not have people's names or other identifying features which would enable people to easily know which their bedroom was. Bathrooms, toilets, lounges and dining rooms had poor signage which made it difficult for people to navigate around the unit. We asked staff about the model of dementia care that the registered provider used and they were unable to tell us about this.

**We recommend that the service explores the relevant guidance on how to make the environments used by people living with dementia more “dementia friendly”.**

# Is the service caring?

## Our findings

People told us that staff were both kind and caring. Comments included “I have one (a carer) come with me to the bathroom, they treat me with respect and care, of course they do, it’s our home and it feels like home”, “I think it’s as good as you can get away from your own home, they knock on the door they are respectful”, “They are good actually” and “They are very good, caring, kind, gentle, I’ve not come across anyone other than that. The staff are lovely and very patient.” Relatives commented “I’m happy with the way they are cared for”, “It took a long time for my relative to settle in and they bent over backwards, the girls have been fantastic with them” and “I have seen them in difficult situations and they are respectful and mindful of people’s needs.”

Information about code of conduct at work and relationships with people who used the service and staff and dress code was available in the employee handbook. This meant that staff had access to information on the standards the registered provider expects from the staff team. Staff confirmed they were aware of these and they gave examples of how they acted to maintain people’s dignity and privacy. Staff explained they always knocked on bedroom doors before entering and when people required support with personal care they ensured this was completed in the privacy of the bathroom. Staff attended to people’s needs throughout the day in a discreet way, which maintained their dignity.

Staff knew people well, for example they knew what people liked, their family background and about their life before coming to live at the home. Two staff were animated and enthusiastic and talked about people in a way that showed us they were caring. One said they had, “A lot of admiration for..” a particular person living at the home. Interactions between people and care staff were pleasant and cheerful. A member of staff said that one of the things that made the home good was, “A high percentage of staff who are very caring.”

Staff told us they enjoyed working in the home. They said they would challenge colleagues if they felt people weren’t being treated properly and would report matters to senior staff. Staff were friendly, patient and discreet when providing support to people.

We heard two comments made during our visit that we reported to the manager regarding the way a carer had spoken to a person who lived at the home. They told one person “If you are a good boy” (you would be able to have a dessert), and when they supported people with eating this was referred to as “feeds”. Both these examples showed that these people were not treated in a caring manner and that the comments were of a derogatory nature. The manager agreed to address these issues.

People were provided with information about the home. We saw a service users’ guide which was called the “Welcome booklet”. The booklet contained information about the home, the statement of purpose, philosophy of care and details of the registered manager and the staff team. This had been reviewed in July 2014.

# Is the service responsive?

## Our findings

People told us staff were responsive to their needs. Comments included “The staff are wonderful”, “The staff are very good” and “The staff are very good to me.” One relative said “When my relative first came in she didn’t like having her door open when in bed, they know that now and they shut the door.”

We saw that a number of people were supported in bed due to ill health, and others who chose to spend time in their rooms. We asked staff how they ensured that these people were not isolated and how they monitored them. We found that one person being cared for in bed did not have access to a nurse call bell because it was positioned behind the bed. Staff said they were unable to understand or use the bell, and this was confirmed in the care plan documentation. Records showed staff regularly attended to the persons needs in relation to re-positioning and comfort. We also observed that ancillary staff provided people with regular drinks throughout the day.

One person told us that the activities were “fantastic” and they joined in with everything. We spoke with activities coordinators to see how they involved people in activities. We were told that people who used the service and their relatives had completed questionnaires regarding people’s likes and dislikes with regard to their interests. This had enabled the activities co-ordinators to develop activities within the home. These were either provided as group activities or individual activities and they maintained records regarding these. The records were analysed as a

way of ensuring people were given an opportunity to participate in activities they enjoyed. The local Church of England vicar was a regular visitor to the home and talked to people in their rooms. We spoke with the Catholic Priest who told us they visited each week.

People who used the service did not have any complaints about the home. A copy of the complaints procedure was displayed in the hallway. Staff knew what to do if anyone raised an issue or wanted to complain. Staff described a form used by the registered provider to record complaints and actions taken in response and they said these completed forms were given to the manager to action. The complaints policy included all the relevant information needed to make a complaint. The manager completed a complaints tracker which showed that four complaints had been made since our last inspection. Complaints records showed that complaints were dealt with in line with the provider’s complaints procedure.

Each person had a care plan in electronic format. These could be accessed by staff at a computer terminal on each unit. Risks people faced were assessed and planned for and included areas such as malnutrition, pressure area care, mobility and falls. Care plans were reviewed each month and updated as necessary.

The manager and staff were very welcoming towards visitors. They offered them refreshments and staff appeared to know the family members who visited regularly. Relatives confirmed they were made to feel welcome at the home. One relative said “I can visit when I like.”

# Is the service well-led?

## Our findings

People said “The staff are good, no problems”, “I have no concerns”, “The manager is approachable.”

The home had a registered manager. We received positive feedback about her from people who lived at the home, visitors and staff. Some of the people did not know who the manager was by name although they said who it was by sight. Staff said that the management team were all approachable and effective. They said that the manager visited each unit most days. They said they felt supported in their role and that if they had any concerns they had the opportunity at any time, as well as at supervision and group staff meetings to discuss them.

One staff member said that the manager was approachable and that they would discuss with her any concerns they had. The staff member also said they thought the values and vision of the home was “For people to feel comfortable and at home and feel able to talk to and ask questions of any member of staff.” They said they had never seen anything that had caused them concern but if they did they would have no hesitation in telling the manager.

Relationships were good between staff and senior staff were good. We found that our discussions with staff had been relayed by them to the deputy manager. The deputy manager said that staff had let them know what they had said about the home in case they had said something wrong.

One relative said “I’m quite happy how things are here. I have recommended it” and another said about the feel of the home “Its brilliant it is a nice feel to come in here, the staff are always pleasant, friendly and caring, it has a nice atmosphere.”

People who lived at the home and relatives had attended regular meetings with the manager. The last meeting was held in June 2015. Copies of the minutes were seen on the notice board in the hallway. The deputy manager explained that sometimes joint meetings were held and on other occasions the meetings were just for people who lived in the home. During these meetings they discussed activity suggestions; menus and food; staffing and any other issues raised. People had confirmed they liked the new menus and suggestions were made for future activities which included an art class; zoo lab; race night and BBQ.

The deputy manager explained that surveys were not undertaken with people who lived at the home as many were unable to complete these and that regular meetings seemed to work well for getting people’s views. A survey was undertaken with the staff team in July 2013 and the deputy manager said they were due to survey staff views. The manager undertook a regular involvement audit which asked 10 relatives and 10 people who lived at the home a range of questions about the care and support they received, the food and the environment.

The registered provider undertook a wide range of audits. These included audits for activities; nutrition; care documentation; falls; low level safeguarding; and the environment. We saw these had been completed on a regular basis and where issues arose, action to be taken was recorded. For example on the care documentation audit it was found that some care plans had not been fully completed. The outcome of this was that group supervision with the relevant staff was undertaken and following that the care records were brought up to date.

This section is primarily information for the provider

## Action we have told the provider to take

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

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

We found that the registered person failed to ensure the proper and safe management of medicines. Regulation 12 (2)(g)