

C.N.V. Limited

# Eversleigh 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?

**Good** 

Is the service responsive?

**Good** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

This inspection took place on 25 and 30 August 2017 and was unannounced. We visited the service early in the morning as we had received concerns about staff levels during the night. At our last inspection of the service on 6 and 7 June 2016 we found the service to be meeting regulatory requirements and was rated 'good'. Eversleigh Residential Care Home provides personal care support and accommodation for up to 30 older people some of which have physical or mental health needs. At the time of our inspection there were 26 people using the service.

There was a registered manager and home manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found a breach of regulations 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.

Medicines were not always managed, administered and stored safely. Staff did not always receive appropriate training updates when required that enabled them to fulfil their roles effectively and this required improvement. There were systems and processes in place to monitor and evaluate the service provided, however these were not always robust or effective and did not identify the issues we found at the inspection. This required improvement.

There were staff recruitment practices in place. Risks to the health and safety of people were assessed and reviewed in line with the provider's policy. There were arrangements in place to deal with foreseeable emergencies and there were safeguarding adult's policies and procedures in place. Accidents and incidents were recorded and acted on appropriately. There were suitable numbers of staff on duty to meet people's needs. Staff new to the home were inducted into the service appropriately. Staff received supervision and appraisals of their work performance.

There were systems in place which ensured the service complied with the Mental Capacity Act 2005 (MCA 2005). This provides protection for people who do not have capacity to make decisions for themselves. People's nutritional needs and preferences were met and people had access to health and social care professionals when required. People were treated with respect and their support needs and risks were identified, assessed and documented within their care plan. People were provided with information on how to make a complaint. People using the service and their relatives were asked for their views about the service to help drive improvements.

## 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 consistently safe.

Medicines were not always managed, administered and stored safely.

There were staff recruitment practices in place.

Risks to the health and safety of people using the service were identified and assessed.

There were safeguarding adult's policies and procedures in place to protect people from possible abuse and harm.

There were arrangements in place to deal with foreseeable emergencies.

We observed there were suitable numbers of staff deployed throughout the home to meet people's needs in a timely manner.

### Is the service effective?

**Requires Improvement** 

The service was not consistently effective.

Staff did not always receive appropriate training updates when required that enabled them to fulfil their roles effectively and this required improvement.

Staff were supported through supervision and appraisals.

The service offered new staff an appropriate induction into the home.

There were systems in place which ensured the service complied with the Mental Capacity Act 2005 (MCA 2005). This provides protection for people who do not have capacity to make decisions for themselves.

People's nutritional needs and preferences were met.

People had access to health and social care professionals when

required.

### Is the service caring?

Good ●

The service was caring.

Interactions between staff and people using the service were positive and people told us that staff were kind and caring.

People were supported to maintain relationships with relatives and friends.

Staff were knowledgeable about people's needs and wishes.

### Is the service responsive?

Good ●

The service was responsive.

People's care needs and risks were assessed and documented within their care plan.

People's needs were reviewed and monitored on a regular basis.

People's need for stimulation and social interaction were met.

People were provided with information on how to make a complaint and complaints and concerns were responded to appropriately.

### Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

There were systems and processes in place to monitor and evaluate the service provided, however these were not always robust or effective and did not identify the issues we found at the inspection. This required improvement.

There was a registered manager and home manager in post and they were both knowledgeable about their responsibilities with regard to the Health and Social Care Act 2014.

People's views about the service were sought and considered through residents meetings and satisfaction surveys.

# Eversleigh Residential Care Home

## **Detailed findings**

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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 25 and 30 August 2017 and was unannounced. The inspection team consisted of two inspectors on the first day and one inspector on the second day. Prior to our inspection we reviewed the information we held about the provider. This included notifications received from the provider about deaths, accidents and safeguarding. A notification is information about important events that the provider is required to send us by law. The provider also completed a Provider Information Return (PIR) prior to the inspection which we reviewed. 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 also contacted the local authority responsible for commissioning the service to obtain their views. We used this information to help inform our inspection planning.

During this inspection we used the 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 also spoke with five people using the service, three visiting relatives, a visiting GP and seven members of staff including the registered manager, home manager, care staff, catering assistant and an activities coordinator. We looked at seven people's care plans and records, staff records and records relating to the management of the service such as audits and policies and procedures. We also looked at areas of the building including communal areas and external grounds.

## Is the service safe?

### Our findings

People told us they felt safe and staff treated them well. One person said, "The staff are very nice, very kind." Another person said, "Oh I feel very safe. Everyone is caring." A third person commented, "I feel very good. I have no concerns or troubles." Throughout our inspection people appeared safe, happy in the presence of staff and were well supported by staff when required. However people's safety was not consistently maintained as medicines were not always managed, stored or administered appropriately.

We spoke with staff about how medicines were managed and administered and observed the morning medication round. Staff told us that only trained staff administered medicines which the manager confirmed. There were three members of staff who were trained and competent to administer medicines. However, staff training records showed that only two members of staff had completed basic medicine administration training in January and February 2016. There was no record of any training for the third member of staff. Staff administering medicines had not received annual competency assessments in line with best practice to ensure they were safe to do so. The last completed annual medicines competency assessment for one member of staff was conducted in January 2016. Staff administering medicines also told us that night staff did not administer medicines other than analgesia if people required this. However training records showed that only one of four permanent night staff had completed basic medicine administration training. This meant that the provider could not be assured that medicines were administered safely by suitably trained and competent staff.

We observed staff administering the morning medications, which were dispensed up until 10:45am. We enquired how this impacted on time specific medicines that were prescribed. In cases where medicines were administered later than the time prescribed, the time difference should be recorded on people's medication administration record (MAR) so that the timing for the next prescribed dose would be adjusted accordingly. However, MARs we reviewed did not record any adjustments including those for the morning of our inspection. MARs were not contemporaneously signed by staff administering medicines as soon as they were dispensed in line with best practice. Staff showed us a printed sheet which had names of those who received medicines. This form was ticked when medicines were administered and MARs were then completed retrospectively; however, we also saw that this additional sheet was not always ticked at the time when medicines were administered and this practice had potential for errors. We drew these concerns to the attention of the manager who told us the contemporaneous signing of the MARs was what was expected of staff; and the separate form was introduced as an 'extra check' to ensure that medication was given.

Some people were prescribed pain-relieving patches, which had specific administration and maintenance guidance for staff administering medicines. Instructions on their use outlined that new patches must be applied to a different skin site each time it was changed and a patch should not be applied to the same site for three to four weeks. In addition, the patch should be applied at the same time of day. There were records in place for each prescribed patch, which included a body map to indicate where the replacement patch was applied. This guidance was not followed or recorded by staff administering medicines. We spoke with the member of staff who told us they were not aware of this guidance.

We observed that medicine trolley temperatures were recorded by staff twice daily and medicines refrigerator temperatures were recorded once daily. Temperature record sheets provided guidance for staff on what safe temperature ranges there should be to store medicines safely. Any recordings outside of these ranges should be reported to the manager and maintenance department. Temperature readings for the medicine trollies were outside the recommended safe storage range on several occasions between 01 July and 24 August 2017. For example readings for the ground floor trolley showed safe temperatures were exceeded on both trollies multiple times. Temperatures for the medicines refrigerator were recorded between 07:00am and 16:00 from 04 July to 24 August 2017. Safe temperature ranges were exceeded a number of times which could affect the effectiveness of peoples medicines. We drew these concerns to the manager's attention who told us they were unaware of these fluctuations in temperature recordings and agreed that the efficacy of the stored drugs could be compromised.

These issues were in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection the manager told us they were in the process of ensuring that staff who administers medicines received up to date medicines training and competency assessments to ensure the safe administration of medicines within the home. They told us they were also in the process of ensuring staff completed and maintained contemporaneous records and would work with the provider to resolve medicines storage issues that we identified. We will check on the progress of these issues when we next inspect the service.

Staff we spoke with told us they felt staffing levels did not accurately reflect the recent increase in people living in the home and in meeting people's increase in dependency levels. They said that the majority of their time was spent attending to people's physical and mental health needs and there was little available time to spend with people or supporting them with activities. One member of staff told us, "Staff are getting stressed out and everyone looks tired all the time." Another member of staff told us how in most cases, staff worked in pairs when assisting some people due to their high levels of dependency and said, "This is absolutely necessary to keep the resident safe, they might fall with only one care worker assisting. This means fewer staff on the floor and I don't think this is recognised by the provider." We visited the service early in the morning as we had received concerns about staff levels during the night. Despite these concerns we saw throughout our inspection that people did not wait long for support when requested, however we noted that staff did appear busy particularly in the morning with little time for pleasantries with people using the service.

Staffing rota's corresponded with the number of staff available on duty at each shift apart from the few occasions when staff were absent due to illness. The manager told us that staffing levels were reviewed to ensure people's needs were met but there were currently three staff vacancies that they hoped to recruit to soon. We will check on staffing levels again when we next inspect the service.

Appropriate recruitment checks were conducted before staff started work to ensure they were suitable to be employed in a social care environment. Staff records we looked at confirmed pre-employment and criminal records checks were carried out before staff started work and records also included application forms, proof of identification, references and history of experience or qualifications.

Risks to people's health and safety were assessed and reviewed on a regular basis to ensure people's continued well-being. Risk assessments identified and assessed levels of risk to people in areas such as nutrition, physical health, mobility, mental health and behaviour and falls amongst others. For example, where people had been assessed as being at risk of falling we saw people's care plans recorded the support

they required from staff to ensure safe mobility within the home and details of any equipment in use to reduce the risk of harm from falling such as bed sensory mats which alert staff should someone fall from their bed.

There were systems in place to ensure accidents and incidents involving the safety of people using the service were recorded, managed and acted on appropriately. Accident and incident records demonstrated staff had identified concerns, had taken appropriate action to address concerns and referred to health and social care professionals when required to minimise the risk of reoccurrence.

There were systems in place to deal with emergencies. People had individual emergency evacuation plans which highlighted the level of support they required to evacuate the building safely in the event of an emergency. Staff we spoke with confirmed that regular fire drills and tests were conducted to ensure they were aware of the correct procedure to follow in the event of an emergency. Safety maintenance checks were regularly carried out within the home such as those for fire equipment, gas and electrical equipment and appliances.

There were safeguarding and whistleblowing policies and procedures in place to ensure people were protected from possible harm or abuse. The manager and staff we spoke with were knowledgeable about safeguarding and the types of abuse, the signs they would look for and action they would take if they had any concerns. One member of staff told us, "I am constantly aware of how a resident can be abused and keep my eyes open for signs." Another member of staff said, "I notice if a resident acts differently from their usual behaviour, especially if it is in response to another person approaching them." Safeguarding records we looked at included local and regional policies and procedures, reporting forms and contact information for local authorities to assist in managing any concerns when required. We noted that appropriate referrals were made to local authorities and the CQC when required.



## Is the service effective?

### Our findings

Staff told us they received training which was appropriate to their needs and throughout our observations staff appeared competent and knowledgeable within their roles. However staff were unable to tell us the frequency of refresher training provided. We looked at the provider's mandatory training record which showed staff had completed manual handling, fire safety and dementia awareness training. However, we saw that other required mandatory training was poorly arranged and attended. For example, six staff out of a potential 22 had completed basic first aid at work training; seven had completed nutrition and dietary training and only one member of staff had completed continence care. Staff told us they had received training in safeguarding adults, however, staff training records listed safeguarding training for just one member of staff out of a possible 22 and this required improvement. We drew these concerns to the manager's attention who acknowledged that mandatory training had not been occurring on a regular basis as required. They told us they had identified some shortfalls in staff training and this formed part of their action plan for the autumn. We will check on this at our next inspection of the service.

There were systems in place which ensured staff new to the home were provided with an induction. This included a period of shadowing experienced members of staff and completing training the provider considered mandatory. Staff we spoke with confirmed that they had received an induction when they started. The manager told us that all new staff were required to complete an induction in line with the Care Certificate. The Care Certificate is the benchmark that has been set for the induction standard for new social care workers. Staff records confirmed that staff had completed an induction programme when they started work to ensure they could meet people's needs safely and effectively.

Staff told us they felt supported by the manager and senior staff and they received supervision on a regular basis. One member of staff said, "The manager is very supportive. I get supervision every few months but always feel I can go to the manager at any time." Staff records we looked at confirmed that staff received supervision on a regular basis and had an annual appraisal when required. The provider had a supervision and appraisal matrix in place which was up to date to ensure staff received continued support when required.

People's comments about the food and menus on offer at the home were largely positive. One person said, "The food is always hot and there is a choice." Another person told us, "I like the puddings best, they are very tasty." A third person commented, "Yes the food is rather nice. It's not like home cooking but it's nice." A visiting relative told us, "The only complaint I have is that my relative does not get enough variety of vegetables. There is nothing that can be done because the meals are brought in already prepared rather than cooked from scratch on the premises." We saw that meals were delivered frozen and pre-prepared and heated in an oven which meant there was little flexibility to accommodate choice. However we spoke with the catering assistant who told us that where someone did not like the meal on offer, they would prepare an alternative such as an omelette or sandwich of their choice. We spoke with the manager about the choice of vegetables on offer and they told us that they could cater to people's choices and would address this at the next residents meeting.

We observed the lunchtime meal in the dining room and saw people were able to make choices about the food they wanted to eat. We saw that where people required support from staff to eat at mealtimes staff were available to provide assistance. We spoke with the catering assistant who was knowledgeable about people's nutritional needs and diets such as the need for soft or moist foods to reduce the risk of choking. People's care plans documented risks relating to people's nutritional needs and detailed guidance for staff on the support individuals required to ensure a healthy diet such as the need for food supplements. Food and fluid charts were also in place where required to ensure people received enough to eat and drink throughout the day and to respond appropriately should health professional's intervention be required. Peoples' weights were regularly monitored where people were considered to be at risk of malnutrition.

Staff we spoke with demonstrated an understanding of the Mental Capacity Act 2005, and the need to obtain consent from people living in the home. They told us how they assumed that everyone had capacity to make decisions. For example, one member of staff told us, "I never rush a decision and will offer a limited number of options to help the person decide what they want to wear or look at." 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 home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager and staff demonstrated a good understanding of the MCA and DoLS and we saw that capacity assessments were completed and retained in people's care files where required. We spoke with a visiting GP who told us that staff proactively asked them to complete mental capacity assessments where there were doubts about a person's capacity to consent or where a person's capacity fluctuated. We saw that a number of applications had been made to the local authority to deprive people of their liberty. Where these had been authorised we saw that the appropriate documents were in place and were kept under review and any conditions of authorisations were appropriately followed by staff.

People were supported to access health and social care services when required in order to maintain good health. We saw that staff monitored people's health and wellbeing on a regular basis and when required sought support from visiting GP's and other health professionals. A visiting GP told us, "I feel confident that when I establish a management plan, care workers will make it happen." Care plans detailed the support people required to meet their physical and mental health needs and where concerns were noted we saw people were referred to appropriate health professionals as required for treatment.

## Is the service caring?

### Our findings

People and their relatives told us that staff were kind, supportive and caring. One person said, "I definitely feel that this is my home; the carers are a wonderful bunch." Another person commented, "Everyone is lovely. The carers are very kind." Comments from visiting relatives were also positive. One relative said, "I think this is a lovely place; staff are all concerned about the well-being of residents". Another relative told us, "This home has a lovely family feel to it; there is a real sense of warmth here."

During our inspection we observed staff engaged with people in an affectionate manner and spent time with people during the afternoon in communal areas socialising and talking to them about things that were important to them. People appeared relaxed and happy in the company of staff and the atmosphere within the home was calm. We saw that staff had built good relationships with people and their relatives and knew them well. One visiting relative commented, "Staff are so welcoming and make me feel involved in my relative's care." We observed that people were free to come and go and visitors were welcomed at any time. Staff addressed people by their preferred names and staff told us of people's preferences and life histories which we saw matched information contained within their care plans and with what people we spoke with told us.

Care plans provided staff with information on people's life histories, preferences and expressed wishes to support them and ensure they could provide people with the most appropriate assistance to meet their needs. Staff were knowledgeable about people's needs with regards to their disability, physical and mental health, race, religion, sexual orientation and gender and supported people suitably. For example where required staff supported people to practice their faith and to attend religious services held within the home.

We saw that people were supported to maintain relationships with relatives and friends and where appropriate relatives were involved in making decisions and in the planning of their loved ones care. A visiting relative told us, "They are very good at contacting me and involving me. They always call me and ask if I want to be involved in my relatives review." Another relative said, "Staff always call me if there is anything wrong. They always ask me if everything is okay or if I want to make any changes." Care plans documented, where appropriate, that relatives were involved in people's care and where required were invited to review meetings and other meetings or events held within the home.

People and their relatives were provided with information about the home in the form of a residents guide upon admission. This contained information about the home, the standard of care people can expect, facilities and activities available within the home and the provider's complaints policy and procedure.

## Is the service responsive?

### Our findings

People told us the care and support provided by staff met their needs in the way they liked. One person said, "The carers are always there if I need them, they are very good like that." Another person told us, "Staff are very good. They know how to help me and the things I like." A third person commented, "I like it here; I get to do what I choose to do." People's needs and risks were assessed prior to admission to ensure they could be safely met by staff. Individual's needs and preferences were ascertained and documented to ensure people's interests, preference and choices were respected. Where people were not entirely able to be involved in the planning of their care, relatives and professionals, where appropriate, contributed to the planning of people's care.

Peoples identified needs and risks were recorded onto a computer based care plan system which enabled staff to document individuals needs for areas such as personal history, physical and mental health needs, nutrition, medicines, recreation and activities, night care, behavioural management, end of life care, dementia and mobility amongst others. Each sections of the care plan contained information on how people's needs should be met and recorded guidance for staff on how best to support people to meet their identified needs. For example one care plan detailed the support the person needed during times of agitation and aggression due to their dementia. It documented that the person responded well to physical sensation of involvement and advised staff of gentle techniques to use. Another person's care plan documented effective communication methods for staff to use when communicating with the person to avoid confusion such as keeping questions and commentary straightforward and not using multiple choice questions which we observed staff doing during our inspection. Care plans were reviewed on a monthly basis in line with the provider's policy to ensure people's needs were met and daily records about people's day to day wellbeing were routinely kept by staff.

A range of activities for people to take part in to meet their need for social stimulation and interaction were provided. The home had a full time activity coordinator in post and whilst the provider agreed funding for external entertainers to visit the home each month, there was no formal budget for in house activities and so the coordinator told us how they had to be creative in how they accessed materials. They told us how they had arranged for a group of volunteers from the National Citizen Service programme to run activities within the home during the summer months. A visiting relative described how their relative enjoyed seeing these young people and said, "They were like a breath of fresh air." The activities coordinator also told us they had secured a ten-week music project funded by the Salvation Army which had recently finished but the professional pianist who was part of this project subsequently committed to doing additional music sessions throughout the forthcoming year.

During our inspection we observed a group activity in the lounge where the activities coordinator encouraged a high level of engagement from people using the service. We saw that activities included games, quizzes and group discussions amongst others. The activities coordinator told us they ran group activities in the morning and spent afternoons with individuals who were either not comfortable to join in a group activity or were cared for in bed. A visiting relative told us how the coordinator "Always gives my relative a wonderful manicure and makes them feel like a million dollars." □

There was a complaints policy and procedure in place and this was on display for people's reference detailing how people could raise concerns and how their concerns would be responded to. People and their relatives told us they knew how to make a complaint if they had any concerns. A visiting relative told us, "I am happy with the care and have no concerns. I know that if I did the manager would address them appropriately." Complaints records we looked at showed that when complaints were received they were responded to appropriately in line with the provider's policy to ensure the best outcomes for people.

## Is the service well-led?

### Our findings

People and their relatives commented positively about the care and support provided by staff and how the manager ran the home. One person said, "It all seems to be managed well here. I have no problems." A visiting relative commented, "The manager is so warm and everyone knows her, which is always a good sign." Another relative said, "The manager acts upon things whenever I raise them." A third relative told us, "The attention to detail which staff demonstrate comes all the way from the top, which means good leadership."

Despite positive feedback from people and their relatives we found failings in ensuring there were effective systems in place to monitor and improve the quality and safety of the service provided and this required improvement. For example we looked at the medicines audits that the manager completed twice per month. We saw how issues detected in one audit were actioned by the following audit. For example, one audit identified that 'as required' medication was not totalled on one person's MAR and this was noted as done within three days of the audit date. However medicines audits conducted did not identify the issues we found in relation to the safe management, administration and storage of medicines as referred to in the safe section of this report. We discussed these issues with the manager who told us they would develop a more robust audit tool that would identify the issues we found and we will check on the progress of this when we next inspect the service.

At the time of our inspection there was a registered manager in post who was knowledgeable about the requirements of a registered manager and their responsibilities with regard to the Health and Social Care Act 2014. However the provider had a home manager in post located at the home and they were responsible for the day to day management of the home. When required notifications were submitted to the CQC appropriately and the manager demonstrated good knowledge of people's needs and the needs of the staffing team. Throughout the course of our inspection we observed the manager spent time with people using the service, their relatives and staff to ensure people's needs were met and the home ran smoothly. Staff we spoke with told us there was good teamwork within the staff group and the manager encouraged this and set an example by her behaviour. One member of staff said, "The manager is really approachable and encourages us to talk things through before they grow into big problems." Another staff member commented, "I would always feel confident to call the manager because I know they will take me seriously." A third member of staff said, "The manager is very good, friendly and supportive."

The manager and staff told us that meetings took place for different staff disciplines within the home which allowed staff to share their views or any concerns. Meetings held included domestic staff, kitchen staff, management team, senior care staff, care staff and the activities coordinator. Minutes of meetings held showed these were used as an opportunity to keep staff informed about changes and the systems in place to run the home. Staff handover meetings were held several times a day at shift changes and also provided staff with the opportunity to discuss people's daily needs and planned activities. We observed the morning handover at 8:15am which included the attendance of two night staff. Discussions included people's night care, staff rota changes, people's planned daily activities and the GP's visit.

Residents and relatives meetings were held on a quarterly basis and provided people with the opportunity to raise any issues or suggestions they had about the home. Minutes of the meetings were made available and we looked at the minutes for the last residents meeting held in May 2017. Discussions included changes made to the service, increase in residents and changes to staffing; activity trips out to the coast and activities within the home. The provider also sought the views of people using the service and their relatives through satisfaction surveys that were conducted on an annual basis. We looked at the survey that was conducted in June 2017. We saw that only eight survey questioners were returned but results were largely positive with people rating the service in each category as either very happy or happy. The manager told us they were in the process of analysing the results and would address any areas of improvement within an action plan if required.

The provider had systems in place to monitor the quality of the service provided. The manager told us and records confirmed that checks and audits were conducted in a range of areas including accidents and incidents, care planning, health and safety, infection control, personnel records, manager spot checks and the home's environment amongst others. We saw action had been taken in response to audit findings where required. For example we saw that when accidents and incident records were analysed, any trends or themes were addressed and if required referrals to health and social care professionals were made as appropriate. We also saw that an action plan was implemented following an audit undertaken of staff records and training as referred to in the effective section of this report.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider failed to ensure medicines were managed, stored and administered safely and appropriately.</p>