Lakewood Limited

# The Sycamores Nursing Home

## Inspection report

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26 October 2017

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

The inspection was unannounced and took place on 19 October 2017. We then arranged to return on the 26 October 2017 to complete the inspection. Prior to the inspection the relatives of one person had raised concerns about care at the home and the inspection followed up on these concerns and we also discussed the information with partner agencies. We last inspected The Sycamores on 22 May 2017, looking at whether the service was safe, which we rated as good.

The home is registered to provide accommodation and personal care, and the treatment of disease, disorder or injury for a maximum of 84 people. There were 78 people living at the home on the day of the inspection. The home is split across three floors comprising a nursing unit, a unit for people living with dementia and a residential unit.

The registered manager left the home in March 2017 and a new manager was appointed. The new manager has applied to CQC to become the registered manager. 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.'

We found that people's medicines were not always available and administered to them as prescribed to meet their health needs. Medicines for four people had been out of stock for a period of four days and action had not been taken to seek advice from a GP or make observations to assess the potential risk to the people concerned.

People told us that they felt safe and they were supported by staff who knew how to keep people safe from harm but they sometimes had to wait for support. Staffing arrangements need to ensure there were enough staff who were organised in the right way to meet people's needs effectively.

Staff had a good understanding of protecting people from the risk of abuse and harm and knew their responsibility to report any concerns.

The principles of the MCA had not been consistently applied. Staff spoken to had limited knowledge of the MCA and how this impacted on the care provided to people. Systems for reviewing DoLS applications had not identified actions required.

Staff understood people's individual care needs and had received training so they would be able to care for people living in the home. There were good links with health and social care professionals and staff sought and acted upon advice received, so people's needs were met.

People's nutritional needs were met. People were given a choice of meals, however they felt the quality of the food they received could be improved. The manager was working with staff to improve people's dining

experience.

People liked some of the staff who cared for them, however care was not provided in a person centred way. Care provided was task focussed and people were not always treated with dignity and respect.

People's access to activities and support varied across the homes three units. We found improvements were needed to support people living with dementia. Relatives said they would like more dementia appropriate activities as there was little for their family members to do and our observations supported this.

Relatives told us communication was good and they were updated on any changes in their family member's health. The manager had introduced new meetings and records which staff told us had improved communication within the staff group. People felt able to raise concerns; however they did not feel actions were always taken in response.

The provider had systems in place to check and improve the quality of the service but these had not been effective in identifying the concerns that we found at our inspection. Audits need to be developed further to ensure that actions had been applied in practice to improve standards of people's care.

The new manager had made some improvements, for example, daily management meetings and a new handover process, but further action was required to ensure that changes were embedded and also further improvements made in a timely way.

You can see what actions we told the provider to take at the back of the full version of this 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 consistently safe.

People's medicines were not always available and administered to them as prescribed to meet their health needs.

Staffing arrangements need to ensure there were enough staff who were organised in the right way to meet people's needs effectively.

People told us that they felt safe and they were supported by staff who knew how to keep people safe from harm.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

The principles of the MCA had not been consistently applied. Care staff spoken to had limited knowledge of the MCA and how this impacted on the care provided to people. Systems for reviewing DoLS applications had not identified actions required. This showed there was a risk that people would potentially be deprived of their liberty when this was not lawful.

The mealtime experience of people needed improvement to enable people to enjoy their meals and support their wellbeing.

People were supported to access healthcare professionals and attend a range of medical appointments.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

People liked some of the staff who cared for them, however care was not provided in a person centred way. Care provided was task focussed and people were not always treated with dignity and respect.

### Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People did not always receive care that met their individual needs in a timely way and did not always receive support to engage in meaningful activities.

Relatives said communication was good and people said they felt able to raise concerns; however they did not feel actions were always taken in response.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well-led.

The provider had systems in place to check and improve the quality of the service but these had not been effective in identifying the concerns that we found at our inspection. Audits need to be developed further to ensure that actions had been applied in practice to improve standards of people's care.

A new manager was in place and some improvements had been implemented but further action was required to ensure that changes were embedded and also further improvements made in a timely way.

# The Sycamores Nursing 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.

We undertook an unannounced comprehensive inspection of The Sycamores Nursing Home on 19 and 26 October 2017. On the 19 October 2017 the inspection team consisted of two inspectors and two experts by experience. An expert by experience is a person who has had personal experience of using or caring for someone who uses this type of care service. One inspector arranged to return on the 26 October 2017 to complete the inspection.

As part of the inspection we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care. We refer to these as notifications. We also received feedback from the local clinical commissioning group who monitor the quality of the service and also asked the local authority if they had any information to share with us about the service. The local authority is responsible for monitoring the quality and for funding some of the people receiving care support. Prior to the inspection the relatives of one person had raised concerns about care at the home and the inspection followed up on these concerns and we also discussed the information with partner agencies. We used this information to plan our inspection.

During our inspection we spoke to 15 people who lived at the home and used different methods to gather experiences of what it was like to live at the home. We observed care and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with eight relatives of people living at the home during the inspection.

We spoke to the manager, the deputy manager, two nurses, one unit manager, two senior carers, one care assistant and two apprentice carers. We spoke to the administration worker and the chef and one of the activities co-ordinators. We also spoke to two healthcare professionals who were visiting the home during the inspection.

We looked at records relating to the management of the service such as, care plans for ten people, the incident and accident records, medicine management records, three staff recruitment files and quality audit records.

Requires Improvement

# Is the service safe?

## Our findings

We asked people if they received their medicines as required. One person told us told us they were still waiting for their medicines because they had run out. We reviewed the management of medicines including the Medicine Administration Record (MAR) charts for nine people to ensure people were supported to receive their medicines as prescribed to meet their healthcare needs. We found that four people had not had access to their medication on time because their medication had not been in stock. For example, one person had not had their epilepsy medication to control seizures for four days. When we asked the nurse about this they showed us they had contacted the doctor to request the prescription; however they confirmed they had not contacted the doctor to discuss the impact on people's wellbeing of missing the medication or completed observations of the people involved to assess and take action on any potential risks.

We checked the providers medication policy, which states, 'In the event that medication is found to be missing, the member of staff contact the service manager and produce a written statement detailing the extract amount of medication missing using the missing medication report.' The manager confirmed that this had not been done for the missing medication identified by the inspector.

We observed a medication round, we saw staff explaining to people about the medication and recording when it was taken. However we saw the morning medication round wasn't completed until 11:30am and some medications were due again at lunchtime. Following manufacturers recommendations some medications require a gap between medications to ensure their effectiveness. We spoke to an agency nurse who was administering medication. They said the lunchtime medications were started later due to the, "Late finish of the morning meds." They advised this was because it was, "Very intensive because there are so many medicines."

We spoke to manager they advised following the findings on the first day of the inspection, a full audit of all medications was completed to ensure that all medications were in place to meet people needs and support their wellbeing. They also acknowledged that the time taken to complete the medication on one unit was too long and advised they would review with the provider if two nurses were needed during the morning to ensure medications were administered in a more timely way.

We found that people's medicines were not always available and administered to them as prescribed to meet their health needs. This was a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People told us they needed more staff to support them. One person told us, "Sometimes (there are) not many staff in the lounge. I spoke to the deputy manager, who told me there was enough staff but I don't think there is." Another person told us they wanted to exercise more but staff had told them they were too busy to help. One relative we spoke to also said that more staff were need. They said, "There always used to be someone (staff) in the lounge. I've notice there seems to be no one (staff) there now."

All staff we spoke with were assured that people were safe. However, six staff told us they felt more staff were needed to provide timely care. One carer said, "More people need assisting, so they all have to wait longer." Three staff acknowledged there were times when there were no staff in the communal lounges to respond to people in a timely way because staff were busy assisting people in their bedrooms. They told us staffing levels had been discussed in staff meetings but they had been told there were enough staff in place. Two staff we spoke to told us nursing needs had increased for people on the ground floor unit, which would benefit from the support of two nurses.

When we spoke to the manager about the concerns raised, they said that staffing was based on both occupancy and people's needs. They acknowledged that people's care needs had increased but felt there was enough staff to meet those needs. They told us they could get agency staff cover when needed and the provider was very supportive and they had used a number of agency staff recently whilst in the process of appointing new permanent staff. When we discussed our finding with the manager they advised they would approach the provider to discuss the need for a second nurse on the ground floor unit.

People told us they felt safe living at the home. One person said, "Yes I feel safe.  It's nice and cosy here." A relative told us they felt their family member was safe with staff to provide support. They said, "It's safer here, [person's name] certainly couldn't live on their own." Staff told us they had received training in safeguarding and identified the different types of abuse. All the staff members we spoke with knew what action to take if they had any concerns about people's safety. This included telling the nursing staff or manager, so plans would be put in place to keep people safe. Staff we spoke with was confident if they raised concerns that action would be taken to protect people.

We checked three staff files and saw records of employment checks completed by the provider which showed the steps the provider had taken to ensure staff were suitable to deliver care and support before they started work. The provider had made reference checks with previous employers and with the Disclosure and Barring Service (DBS). The DBS is a national service that keeps records of criminal convictions.

Requires Improvement

# Is the service effective?

## Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application for this in care homes and hospitals are called Deprivation of Liberty Safeguards DoLS. We looked to see if the provider was working within the principles of MCA.

Staff told us that they had received MCA and DoLS training; however, staff we spoke with were not clear about their role and responsibilities with regards to DoLS, for example what authorisations in place meant for the individual people We found that principles of the MCA had not been consistently applied. For example, we saw that DoLS authorisation were in place for two people; however we noted that of the conditions of the authorisations had not been actioned. The system for reviewing DoLS applications had not identified this issue. The failure to recognise and action the conditions of the authorisation meant that the person was deprived of their liberty when this was not lawful.

We also found records showed that four DoLS authorisations had expired. We could not see if a review had been completed to assess if the four people concerned were still being deprived of their liberty and new applications needed to be made. This showed there was a risk that people would potentially be deprived of their liberty when this was not lawful.

We spoke to the manager about the DoLS information and staff training. They advised they had not had opportunity to review the information since they had started at the home and advised that the information would be reviewed following our inspection.

The provider did not ensure people were not deprived of their liberty when this was not lawful. This was a breach of Regulation 13 (5) HSCA 2008 (Regulated Activities) Regulations 2014.

People told us they felt staff had the skills to meet their needs. One person said, "The staff are good, you can't fault them," and described how the staff were skilled in the support they gave them in their skin care. Staff told us they had undertaken a range of training so they could provide the support and care people living at the home needed. Three staff said training had improved since the new manager had been in post as the manager had made a link to a local college to access more distance learning opportunities for staff.

We spoke to the manager about staff training; they advised that they were a qualified trainer themselves and since starting at the home they had reviewed some of the training provided. The manager felt some training could be improved, for example, manual handling training, and was in the process of organising new

training.

Staff we spoke with understood the importance of obtaining people's consent when supporting them. However, observations we made showed that staff gave direction rather than seeking peoples consent. For example, we saw staff directing people when supporting them to sit in their wheelchairs. Staff were heard to say, "Put your feet here," and, "Lean forward. We also heard tell one person, "I'm taking you to the dining room now." Staff members we spoke with told us where people were unable to give verbal consent they looked for facial expressions and hand gestures to gain consent and enable people to communicate their choices. People told us staff respected people's right to refuse support. One person told us, "There's activities on offer but I'd rather read my books, staff understand this and respect it." Another person told us, "I feel able to speak up (tell staff what I want), they do listen."

People told us they were given a choice of meals. One person said there was a choice and, "If I don't like it they will get me something else." However, we heard mixed views from people about the quality of the meals they received. One person told us, "Can't say its anything special," and another person said, "It's the same things all the time."

One person told us they chose not to go to the dining rooms for their meal as, "The dining room is cold and dreary." We saw a lunchtime meal on the first day of our inspection; there was little interaction between people and varied interaction between people and staff. For example, in one dining room we saw some people were served their meals with no conversation or acknowledgement from staff, whilst in another dining room staff chatted more to people. A choice of two meals was served from a hot trolley; once the meals were served the trolley was removed therefore there was no option of people requesting more if they were still hungry.

We saw some people were assisted by staff to eat their meals; although people were given time to eat their meal there was little conversation or encouragement from staff. We saw one person push away their meal uneaten. A member of staff said, "You need to eat [person's name]. Give it a try," but they did not stop to offer encouragement or offer an alternative.

We spoke to the manager about people's mealtime experience. They advised that they had observed meal times and agreed that there needed to be more a 'better atmosphere' and more interaction with staff. They advised that they were had ordered new table mats which people were going to individually decorate and were looking at ways to make further improvements.

We saw that people were supported to have drinks throughout the day. People were given a choice of drinks at meals times and throughout the day. One person told us they enjoyed a cup of tea from the night staff each morning and we saw jugs of water or juice in some people's room.

We spoke to the chef and they told us how they worked together with care staff to ensure that people's individual needs were catered for. The chef confirmed choices were offered and said if people wanted something else they would provide a further option, for example, a baked potato or sandwich. The chef told us that people's preferences and dietary requirements were recorded in care plans and updated when required. They gave examples of some of the individual preferences of people. The chef said, "If they like it, why shouldn't they have it?" They advised they felt supported by the provider for food and equipment. They told us, "For me it's a really positive place to work."

We saw that people were supported to access healthcare professionals and attend a range of medical appointments including GP and optician. One person told us, "When I was unwell, two doctors came in."

One relative commented, "They [staff] do pick up if [person's name] is unwell.  When they are poorly they get the doctor in.

We spoke to health care professionals visiting the home during our inspection. They both described the healthcare as 'good' and said referrals were made appropriately and that staff knew people well.

Requires Improvement

# Is the service caring?

## Our findings

People told us the care they received was inconsistent and depended on which member of staff provided the care. One person said, "Some are kind and helpful, some don't care." Another person told us, "Some (staff) do (care), some don't," and a third person told us, "I don't think they (staff) are interested." One relative also commented, "Some staff are obviously better than others."

Our observations supported this; whilst we saw positive interactions from some staff other staff appeared task led rather than people led. For example, we saw several people supported to transfer from their wheelchairs into armchairs. Although staff did this safely, we saw on several occasions this was done without talking to the person to explain to them what was happening and offer reassurance. On several occasions, we also saw staff walk through communal lounges where people where sat, without acknowledging them.

At lunchtime we saw some staff asked people if they would like their food cut up to help them to eat their meal. However, other staff did this without asking or communicating with the person. We also observed one person was supported by a member of staff to eat their meal in their bedroom. There was no conversation or encouragement provided and when the person finished eating the member of staff left without reference to the person.

Staff were not always respectful when they were talking with people or to other members of staff about people's care needs. For example, we also saw staff talking over the top people during lunch to discuss which people still needed serving with lunch and which other staff were coming onto duty. We also saw files containing peoples personal information on skin care and their nutritional intake, were left out in a communal lounge.

We spoke to the manager about this, they told us they had made observations of the meal times and acknowledged some staff were task orientated. In response, they had spoken to the provider about sourcing additional training for staff. They also took immediate action to ensure peoples personal files were stored away correct to maintain people's confidentiality.

During our conversations, staff we spoke with had a good knowledge of people's individual needs. Staff understood the different ways that people expressed how they felt. We also saw staff responded to the body language of one person and offered support in a timely way. For example, we saw that when one person became anxious staff supported them and gave reassurance until they became more settled. We also saw some staff talk to people about their families and the things that were important to them, which we saw people enjoyed and responded to.

People's friends and relatives visited when they chose, the provider asked that people did not visit over lunchtime which visitors understood and respected. One relative said, "I visit often. I chose when I come and staff always chat to me."

Requires Improvement

# Is the service responsive?

## Our findings

People told us that care was not always responsive or provided in the way that they would choose. For example, people also told us they were not able to choose the time they had breakfast. One person told us, "I used to get up at 8am but I have to wait until 9.30am now. Breakfast is at 10am when I have porridge but I then have to wait for toast. Lunch is then too soon at 1pm." Another person told us I would like (breakfast) a bit earlier but I have to wait. I have mentioned that I would like breakfast sooner in a joking way; staff say there's all the others (to serve)."

One person also told us following a change in their health; they had requested a different breakfast choice but staff continued to bring their previous choice. One the day of our inspection the previous choice had been delivered. We saw that at 11:10am the breakfast remained un-eaten whilst the person waiting for their preferred option to be delivered.

We made observations that supported this. One the second day of our inspection we observed one person asking for breakfast. A member of staff sat with them to chat and they were given assurances that a bacon sandwich was on its way. The person continued to tell the member of staff they were hungry. We saw staff supported the person to the dining room where they were served with porridge 50 minutes after first asking for their breakfast. When they ate all their porridge quickly, one member of staff said, "Goodness you are hungry," and acknowledged this was because they had 'been up a long time.'

We noted people's choices and preferences were not always sought. For example, background music was played on the radio whilst people ate their lunch. We saw a member of staff change the radio without asking any of the people or asking them their preference for the choice of music. We also noted 15 people watching TV in one lounge. One person said about the television programme, "This is rubbish." We asked how programmes were chosen. The member of staff said, "We ask [person's name] or [person's name]. Others aren't fussed. Some can't talk so you don't get much out of them."

We spoke with people and observed how staff supported them with their hobbies and interests. People's experience of how they were supported varied dependent on which area of the home they lived. Some people told us they enjoyed individual hobbies such as reading, knitting and music. One person told us they enjoyed reading bible passages brought in by visitors. Other people told us they enjoyed the parties at Christmas and Halloween. However some people told us they would like more activities. One person said, "There's nothing to do except watch television." Another person echoed this and added, "I don't know what I would do without my television."

There were some activities organised for people across all three units of the home to attend. For example, on the first day of our inspection there was a Diwali celebration. However, people on some of the units missed the celebration because the time of the celebration was miscommunicated.

During the inspection we observed people that on the unit for people living with dementia, had limited access to activities. We observed three people and saw they received little or no encouragement from staff

to engage in activities. One relative told us their family member did not receive the support they had anticipated they would to pursue interests. They said, "There are no activities [person's name] would choose to take part in." We spoke to one of the activities coordinators, they acknowledged improvement was required on but said things were improving under the new manager; who was supporting new activities and asking people for their choices.

We looked at how information was shared between staff to ensure people's care needs and risks to their wellbeing were known. We saw that a new daily meeting had been put in place to share information across the home. Staff told us this was working well in sharing information each day. A new handover record sheet to record more detailed information had been designed and was due to be put in place. On the day of the inspection we were unable to determine how effective the handover was as it as it was not yet in place.

Two members of staff told us if they had any concerns they could report them to the manager. One of the staff gave an example of a concern they had raised and said they felt listened to. Two other staff said that if they had concerns they would go straight to their unit manager. Three relatives told us they felt communication with families was good. For example, one relative told us, "Staff always update on any changes." Two relatives also gave example of when they had been communicated with and said staff would also update them whenever they visited. We also noted staff were organising a skype call for one person so they could speak to their relatives abroad.

People told us were not enabled to be involved in planning their care. People and relatives we spoke with were not aware of their care plans and said they were not involved in reviews. One relative commented, "[Person's name] is not involved in meetings."

We received mixed comments about raising any concerns with staff. For example, one person told us, "I would let them (staff) know." However, two relatives told us they had raised 'low key' concerns and were awaiting a response. One person also commented, "I raise concerns with [staff member's name]; listens but doesn't always take action." We saw that the manager had a complaints folder in place. All written complaints had been logged, investigated and responded to. The information showed actions taken by the provider.

Requires Improvement

# Is the service well-led?

## Our findings

Since our last inspection there had been changes in the management of the home. A new manager had been appointed and has submitted an application to become the registered manager at The Sycamores. 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.'

We looked at the governance systems because we wanted to see how regular checks and audits led to improvements in the home. However, we found these were not always effective. The checks had not identified the concerns that we found at our inspection. For example, medication audits had not been effective in ensuring that people's medications were ordered in a timely way to ensure they had sufficient medication available. The provider's audit systems had failed to identify that one nurse on the Oak unit was insufficient to ensure people received their medication in a timely way. In addition, audits had not identified that the conditions of two DoLS authorisations had not been actioned and that four DoLS authorisations had expired.

We saw the provider visited regularly to review the service. We saw reports completed and the manager told us any areas identified for improvement were discussed and agreed and were checked on the next provider visit but these need to be developed further to ensure that actions had been applied in practice to improve standards of people's care. All management information was also entered on the provider's computer system so the provider had up-to-date information on any incidents at the home and the actions taken. However, we found the system of filing and organising quality assurance audits was ineffective. Completed audits were not organised in a way that information could be accessed easily to ensure any required actions were monitored and improvements made in a timely way.

People told us overall they were happy living at the home but would like some changes, for example, more staff to support their personal choices. We saw that a residents meeting had been held on the week of our inspection. Notes of the meeting showed people had raised concerns about staff support in the morning and said they would like more activities. The manager had given assurances that this would be reviewed and actions taken to address the concerns.

We saw the manager had introduced some new initiatives, for example, a daily meeting for all senior staff to meet and share information. One member of staff we spoke to said, this was an improvement and resulted in information to support people's needs being shared more effectively. The manager said this meeting was new to the home and appeared to be working well but would need more time to fully embed.

The manager commented that they had taken time to assess the service and identify any areas within the home that needed to be improved, for example, an improved dining experience for people and a new handover for to staff to share information to support peoples care needs. They advised an action plan of priorities was planned but not yet completed. On the day of the inspection we were unable to determine

how effective the plan was as it as it was not yet in place.

We asked staff about the support they received. Staff told us there had been a period of change and some improvements, however, three members of staff said they would like more structured and frequent supervision. We spoke to the manager about this and they advised that a new schedule of supervisions had been arranged and was due to commence, this was acknowledged by staff.

Staff told us there was always someone available to speak with them if they had a concern, for example, the nurse. Staff told us they generally felt supported by the provider representative, who staff told us made regular visits and had met with staff. However some staff were frustrated by the lack of action in some key area's such as staffing levels.

The manager and provider audits were not effective in monitoring the quality and safety of the services provided. This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance.

The manager told us they felt well supported by the manager. As a new manager they received a daily call from the regional manager. They also received advice and support from the registered managers from the providers other homes and could download information from the provider's computer system. To keep their knowledge up-to-date they were completing a manager training qualification, they attended managers meeting arranged by the local authority and also accessed the CQC website for information and guidance.

We spoke to the Clinical Commissioning Group (CCG) prior to our inspection. They confirmed that the manager had accessed training for pressure care and some staff had enrolled in a skin care training programme. They also confirmed that the manager had also attended monthly meetings with other care home managers.

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<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br>People's medicines were not always available and administered to them as prescribed to meet their health needs. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br>The provider did not ensure people were not deprived of their liberty when this was not lawful. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br>The manager and provider audits were not effective in monitoring the quality and safety of the services provided. |