Brunelcare

Saffron Gardens

Inspection report

Devon Road
Whitehall
Bristol
BS5 9AD

Tel: 01179396681
Website: www.brunelcare.org.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 18 April and was unannounced. The service was last inspected in January 2015 and was rated Good at this time. No breaches of regulation were found.

The service provides accommodation and nursing care to older people, many of whom are living with dementia. The home provides care for up to 94 people; this includes a reablement unit for up to 24 people who are being supported to return to their own homes. There are also private flats included in the building and the people living in them are able to access support from care staff if required. At the time of our inspection, one person living in the flats was receiving a package of care from staff.

There were two registered managers at the service. One was in day to day charge of the reablement unit and the other in day to day charge of the rest of 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 service is run.

People living in the home felt safe and well cared for. We received positive comments about staff and how safe people felt. Comments included; "Yes I feel safe everyone seems so pleasant and easy to talk to" and "Couldn't be better, I feel safe here and the staff are very sociable and kind to me."

There were inconsistent practices across the home in relation to medicines and risk assessment which meant improvements were required. When medicines were being crushed and administered covertly, we saw that in some cases pharmacist support had been sought in making the decision but not always. Pharmacist input is necessary in order to establish that crushing medicines is safe to do so. There were also inconsistencies in the recording of topical cream administration.

Where risk assessments were being used to assess people's needs, we found in some cases these were clear and gave clear information about how to support people. In other cases we found errors in how they had been calculated and therefore didn't accurately reflect the person's needs.

These concerns had not been identified through the provider's own quality and safety monitoring procedures.

We found some good practice in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Where best interests decisions were required, these were documented. We discussed with the provider further ways that they could ensure the requirements of the act were fully met, in terms of ensuring all views were sought from relatives when making decisions.

Staff received training and support to carry out their roles effectively. Staff received regular supervision to ensure their performance and development needs were monitored.

People were supported by kind and caring staff. We saw staff demonstrating care and attention to the people they supported. People were able to take part in a range of activities suited to the needs of people living with dementia.

There was a clear management structure in place in the home. The two registered managers were supported by a deputy manager and senior staff leading individual units. Staff felt that communications was good within the team and told us regular meetings were held to ensure important information about the running of the service was shared.

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

There were some inconsistencies in the management and administration of medicines across the home.

There were inconsistencies in how well risk assessments were used to ensure that people were safely cared for.

People were protected from the risk of abuse because staff were trained in safeguarding vulnerable adults and knew the procedures to follow if they had concerns.

There were sufficient numbers of staff to ensure people were cared for safely.

Is the service effective?

Good

The service was effective.

People's rights were protected in line with the Mental Capacity Act 2005 and DoLS

People received support from healthcare professionals when required.

People were supported to ensure their nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring.

People were able to maintain relationships that were important to them.

Is the service responsive?

Good

The service was responsive

People in the reablement unit of the home received care that was flexible according to their needs.

People had person centred care plans in place to guide staff in meeting their needs.

People were able to take part in activities suited to the needs of people living with dementia.

There was a system in place to respond to complaints.

Is the service well-led?

Requires Improvement

There were two registered managers in place supported by a deputy manager and senior staff in each area of the home.

There were systems in place to monitor the quality and safety of the service provided, however these were not fully effective in identifying breaches of regulation.

Staff were positive about working in the home and the support they received.

Saffron Gardens

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 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 an updated rating for the service under the Care Act 2014.

The inspection took place on 18 April 2017 and was unannounced.

The inspection was undertaken by two inspectors, two specialist advisors and one 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.

Prior to the inspection we viewed all information available to us including notifications and the Provider Information Return (PIR). Notifications are information about specific events the provider is required to send us by law. The PIR is a form that the provider completes to tell us about the things they are doing well and the aspects of their service they are seeking to improve.

During the inspection we spoke with 11 people using the service from across all areas of the home and reablement unit. We spoke with relatives of three families. We reviewed care plans for 16 people. We spoke with staff members.

Requires Improvement

Is the service safe?

Our findings

Comments from people using the service and their relatives included; "I don't feel worried when I leave here; I know my relative is safe", "I feel very safe", "I feel safe having people around me as I do not like being on my own. I like that there are always people to talk to you here "and "I like it here. I live here with my wife I feel very safe here".

Medicines were inconsistently managed across units. Although medicines were administered safely, and were securely stored, supporting documentation in relation to the administration of covert medicines was variable. In addition, the management of homely remedies was poor.
We observed part of a medicines round on Orchard Court. On this unit staff were using an electronic medicines system called EMar. The nurse administering the medicines used a tablet device to identify which medicines were due and to record when they had been administered. The nurse knew people well, and took their time when assisting people; they did not rush them, ensured they had a drink and asked them if they needed any additional medicines such as pain relief. There was a system in place to ensure that all medicines had been administered as prescribed.

On the other units we saw that the Emar system was not in use and that staff were using a paper system for recording when they administered medicines. When we checked a selection of medicine administration record (MAR) charts, we found that generally these had been completed in full.

Although there were protocols in place for when people required PRN (as required) medicines, these were not seen consistently in all units. PRN protocols aid staff by guiding them to when people might need additional medicines and the reasons why.

Topical medicine administration records were not consistently completed. For example, one person had been prescribed a soap substitute, but records had only been signed on four occasions during April 2017. Another person had been prescribed a cream "twice a day to areas of dry skin", but records had only been signed twice during April 2017. Another person had also been prescribed a cream and the directions read "apply to skin or use as a soap substitute". It was difficult to confirm whether this had been applied at all during April 2017 as the records were not dated.

Some people were having their medicines administered covertly. This is when medicines are "disguised" in food or drink and can also include crushing medicines. When medicines are administered this way to people who are unable to consent, mental capacity assessments and best interest meetings should take place in accordance with legislation. On Orchard Court we looked at the documentation in place for one person who was having their medicines crushed and mixed with liquids. There were clear records in place to show that the GP, the pharmacist, a nurse and the person's family had been involved in the decision making process and that the decision to administer medicines this way had been reviewed to ensure it was still in the person's best interests.

However, on other units this documentation was not always in place. For example, on Hazel Unit we looked

at the records for three people who were having their medicines administered covertly. For one person there was a letter to a GP asking for permission to administer the medicines covertly. This was dated 12 September 2016. Although the letter had been signed by the GP, there was no documentation in place to show how the decision had been reached or how often it should be reviewed. In addition, it had been documented that the person's tablets should be "crushed and mixed with diluted blackcurrant, stirred well and administered. It is in (person's name) best interests". Crushing medicines can alter the way their mode of action and as such a pharmacist should also be involved in discussions to ensure it is safe to do so. However, there was nothing documented to indicate that a pharmacist had been consulted. In addition, when we looked at the persons' medicine administration chart, the instructions for one medicine were "Do not chew or crush".

We also found inconsistencies in the use of risk assessments. We saw examples of some that had been completed well and gave clear guidance for staff on how to manage the risk. However in other examples we found unclear assessment or ones that had not been completed accurately. We found assessments for skin integrity and nutrition, where the scores had not been accurately calculated and therefore the level of risk identified was not a true reflection of the person's needs. For some people we found there were no clear risk assessments for the use of bedrails and when we checked these, we found some were not adjusted to the safe recommended height.

This was a breach of regulation 12 2 (b) and (g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People in the home were protected from the risks of abuse. Staff had an up to date understanding about the different types of abuse that could occur in a care home and other settings. The staff knew what to do if they needed to report concerns about people at the home. They told us they felt very able to approach the registered manager or other senior staff if they were at all concerned about someone. Staff confirmed that they had been on training about the topic of how to safeguard adults from abuse. The subject of safeguarding people was also raised at staff meetings and at one to one supervisions meetings. This was to ensure that the team knew how to raise any concerns and what to do to keep people safe.

The staff members that we spoke with understood the different legislation used to protect the rights of the people they supported. We saw a copy of the procedure for reporting abuse on display on notice boards in a number of areas of the home. The procedure had been written in an easy to understand style. This was to help to make it easy to use. There was also information from the local authority guiding people how to report abuse.

The registered manager reported all concerns of possible abuse to the local authority and told us when they needed to. Staff understood what whistleblowing at work was and how they could do this. Staff explained they were protected by the law if they reported possible wrongdoing at work. Staff had also been on training and further updates to help them understand this subject. There was a whistleblowing procedure on display in different areas of the home. The procedure included the contact details of the organisations people could safely contact.

To help to reduce the risk of unsuitable staff being recruited the provider had a robust was a recruitment procedure in place. This helped reduce the risk of unsuitable staff being employed. New staff were only able to start work after a number of checks had been completed. These included references, proof of identification and criminal records checks. Staff we spoke with told us they had undertaken these checks. Disclosure and barring (DBS) checks were carried out on all the staff. This DBS help to ensure that only staff who are suitable are able to work with vulnerable people. There were proof of identification checks in the

form of passports, or other photo ID completed for all staff. Checks were also carried out to ensure that registered nurses were properly registered with the Nursing and Midwifery Council. This is the registered body that ensures only nurses who are considered to be fit to practise can nurse in England.

We found good practice in relation to recording of incidents and accidents. The forms used described the immediate action taken to address any injuries and long term action required to prevent reoccurrence. We also saw that where a fall had occurred, a sheet attached to the form detailed that regular checks had been on the person following their fall.

There were sufficient numbers of staff to ensure people were safely cared for. The registered manager told us that the use of agency staff was decreasing as result of permanent staff being recruited. Throughout the day we observed care being delivered in a calm manner with people's needs being met promptly. People told us "Yes I feel safe everyone seems so pleasant and easy to talk to. I would use the call bell; I have used it once staff came quickly. I think there is enough staff but sometimes they can take a little while to come" and "The staff are pretty good I know they are around about and if I will call them they will come". Another person told us ""There always seems to be enough staff on duty".

Good

Is the service effective?

Our findings

People were cared for by suitably qualified, skilled and generally well supported staff. There was a system of staff supervision for monitoring the team's performance and their development. The staff told us they met with their named supervisor and other staff to review how they were performing. They also explained that at each meeting the needs of people they supported were discussed with them. We checked the records of recent staff supervision meetings for staff on each of the units. We saw that staff received regular performance supervision and appraisal. The supervision and appraisal records we saw generally showed that staff highlighted set objectives with their supervisor .These included for example, any training the staff member wanted to go on. This would then be reviewed with them through the year. In addition to this, a discussion was held relating to the staff members performance and they were given clear feedback about their performance during the year.

We found that three staff in the nursing unit had not been receiving regular one to one supervision from a supervisor. The provider's policy stated that it was aimed for all staff to meet with a supervisor at least every three months. Supervision is a process that can be used among staff to reflect on and learn from practice. It is also a way to provide personal support and professional development. This meant there was a risk that the staff were not carrying out their roles effectively as they may not have been properly supported.

Newly recruited staff were supported to undertake their new roles by an in depth induction programme before they began working at the home. The induction programme covered a range of learning about different health and safety practises and procedures, the needs of older people, safeguarding people from abuse, and correct moving and handling. They were also inducted about the needs of people who lived at the home and how to meet them. Recently employed staff who told us they had completed an in-depth induction programme and this had included working alongside experienced staff. The staff said this was a good way to learn how to provide effective care.

Staff benefited because the provider had a positive learning culture for employees. The staff all told us they were supported and encouraged to go on further training if they wanted. They told us they could approach their line manager and discuss with them further earing needs that they felt they had. Training was then arranged for them. One staff member for example, told us they had asked to go on some training about a person's specific health condition. Training had been put in place for them. Training records confirmed that there was range of training available for staff. Sessions staff had been on included person centred care, understanding Parkinson's disease, caring for people with dementia, nutrition, wound care, and medicines management. This was to help to ensure staff had the right skills and approaches effectively meet the needs of people at the home.

The Mental Capacity Act 2005 is a legal framework to support decisions to be made in the best interests of adults who do not have the capacity to make an informed decision. There was guidance available about the Deprivation of Liberty Safeguards Law (DoLS). This information meant staff could get hold of guidance, if needed to ensure safeguards were in place to protect people in the least restrictive way. This information also helped to inform staff how to make a DoLS application.

The staff had completed Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training. The members of staff that we spoke with had a good understanding of this law. They were able to explain to us that a key principal was the assumption that each person had capacity until assessed otherwise. Staff gave us examples of when a person had been assessed as not having mental capacity. These included assisting a person with intimate personal care who did not fully understand why this support was needed for their health and wellbeing.

For those people who had a DoLS authorisation in place, there was a care plan associated with it to ensure that any conditions on the authorisation were met. In one example, we saw that there was a condition to the DoLS to provider further reminiscence activities. There were records that this had been discussed with family members and activities put in place to address this condition.

We viewed people's files to check whether the principles of the Act had been followed when making decisions on behalf of people who lacked capacity. We saw that a Mental Capacity Assessment and best interests decision had been made for people where sensor mats were in place. However we discussed with the registered manager how it appeared that the decision had not included the person's representatives to ensure all views and wishes were known. The registered manager told us this was something that they had already identified and were looking to improve. This was also evident in the administration of covert medicines where practice was inconsistent in involving family and relevant professionals. This has been reported on, under 'Safe'. We also noted that where people had wounds and photographs had been taken to monitor the progress of the wound, consent had not been sought in relation to taking the photographs. Following the inspection, the provider sent us documentation that was due to be introduced that recorded whether a person consented to photography.

The registered manager had made applications to the local authority for people who needed to be deprived of their liberty in order to receive safe care and treatment. Details of the applications were kept in a log so that the process of the application could be monitored.

There was information contained in people's care plans about their food and meal preferences. Assessments were also undertaken to identify people who may be at risk nutritionally. Feedback from people was generally positive about the food at the home, although some people did say they would prefer more options that met their cultural needs. Comments included; "The food is very nice I like the fish and chips", "I like the dinners here I enjoy Weetabix I have it every morning. If I am hungry I can always have a snack" and "The food is alright, I enjoyed the lunch today".

The chef told us how meals that reflected the cultural needs of people were included in their menu planning. For example Caribbean options were included to reflect the cultural background of a number of people living in the home.

We observed mealtime on one unit of the home and saw that people were well supported and food was attractively presented. People were shown pictures of the meal options to help them choose what they would like.

People had support from healthcare professionals in accordance with their needs. On Orchard Grove, where people stayed for short periods of time with a view to moving back in their own homes, there were physiotherapists and occupational therapists available on a regular basis to support them in meeting their goals. During our visit, we also saw that specialist nurses visited the home to support people with any damage to their skin. We noted in other people's care plans that professionals such as GPs and chiropodists had been involved in supporting people when required.

Good

Is the service caring?

Our findings

People were positive about their experiences of living at Saffron Gardens; comments included "Couldn't be better, I feel safe here and the staff are very sociable and kind to me. I am not worried about anything if I was I would complain to the manager" and "It is a nice place here and I feel settled and I would recommend other people to come here if they needed to". A relative told us "good to see the care that other people receive it gives us confidence. Dad is treated with dignity here and he is given lots of affection and the staff hug him a lot. Dad likes eye contact and I think the staff go the extra mile to make him happy". Another person told us "I'm really very happy. The staff are my friends. They call them care staff, but in this establishment, care is spelt LOVE".

Shortly after our inspection, the provider sent us a copy of a letter from a family member thanking Saffron Gardens for the care provided to their relative. Staff were described in the letter as 'patient, kind, compassionate and respectful'.

We saw that the staff all treated people in a caring and kind manner. The staff were friendly, polite and respectful when providing support to people. Staff spoke with people in a gentle and caring way whilst providing care or assisting them with their meal. Some people preferred to spend time in their rooms we saw staff went in on regularly to see how they were. Staff spent time with people outside of care tasks. We saw one person sitting outside in the garden area of the home and staff sat with them keeping them company. We also saw staff interacting pleasantly with people whist engaged in activities such as bingo. Other staff members were observed comforting people who had become agitated, speaking gently with the person and gently touching their arm. On another occasion a member of staff sat with a person and took interest in the cooking books they were reading.

There was an open visiting policy and visitors were able to have a free meal with their relatives at the home. We saw people having lunch together with their relatives and looking very relaxed and animated together. Relatives were also invited to any parties and social events that took place regularly at the home. This helped people to stay close to those who mattered to them. One person in the home had previously visited a day centre but was no longer able to. During our inspection staff and friends from the day centre came to visit the person and they went to socialise together in one of the communal areas of the home.

There was information in people's care plans about the aspects of their care they could manage independently; for example in one person's care plan it detailed how the person was able to dress themselves with verbal prompts from staff. During the inspection we observed staff offer support when required but also allowed people to be independent where they were able. For example one person got up from a chair unaided; a member of staff made sure they were close by and offered their assistance if required.

Good

Is the service responsive?

Our findings

We received positive comments from people about how well their needs were met in the home. One relative told us said "my father been getting better since being here he is very safe and I am very impressed with it. I have no concerns at all, my father has improved and has become involved in lots of activities". Another person told us "my husband came from a different place, now that he is here he's really happy".

Care provided in the reablement unit of the home was responsive and flexible according to people's needs. The length of time people spent in the unit was planned according to the individual and goals were in place to support the person in achieving their aim of returning to their own home. These goals were regularly evaluated to check the progress the person was making.

People had care plans in place to guide staff in meeting their needs. Plans were person centred and gave good information about how to support the person, including details unique to the individual such as the kind of programmes they liked to watch on TV and the clothes they liked to wear. Care plans were updated when necessary; for example we saw an example of a care plan that had been updated following the person experiencing a fall. We did note however, for one person who had a wound to the skin, there wasn't a specific care plan in place to manage the wound, though regular assessments did take place to monitor how the wound was progressing.

Staff were able to understand and meet people's needs. On one occasion we saw two people in the home begin arguing. A member of staff managed the situation by calmly encouraging one of the people to come with her to check what was on the menu for lunch. The person responded to this and walked away with the staff member and this meant that the situation didn't escalate further and people were safe.

The inside of the home had been adapted in a number of areas to make it suitable for people with dementia. There were mock-ups of a shop and a pub. We saw that both were popular areas with people who lived at the home. There were secure garden areas with bright flowers and garden benches where people could safely sit and pass the time away from staff. Other areas of the home had a musical theme, a seaside theme, and a dressing up theme that included old style hats, jewellery and clothes. These were creative ways to stimulate people and provide opportunities for reminiscence with them. For reminiscence and stimulation parts of the home were adapted with photos of old film stars, singers and entertainers. There were also pictures of old style adverts on display. Different parts of the home were decorated in bright colours, and staff wore different bright coloured clothes to assist people to recall what part of the home the staff worked in and where they were living.

One person had brought their cat to live with them at the home. We saw that the cat was liked by the people who lived there as they responded warmly to it.

People benefited from a range of social and therapeutic activities in the home, which were suitable for their needs. We saw an outside entertainer put on a show for some people. The entertainer specialised in providing entertainment for people with dementia. They used a variety of memory prompts with people as

part of their show. We saw people were laughing, joking, and responding in a positive way. Full time activities co-ordinators were employed to facilitate a varied activities programme. People took part in games and a musical afternoon during our visit.

There was a very flexible timetable of social activities that took place in the home each day. Activities were planned in a relaxed and informal way, due to people's dementia type illnesses impacting on their memory and ability to engage. Activities that took place included regular visits from different musicians and singers, drives to the community, and hand and nail massages. There was a gardening group, cooking demonstrations and themed events such as parties and celebrations of festivals and important dates in the calendar.

Other activities included visits from external entertainers and outings during the warmer weather. Church services were held regularly which helped to ensure certain people's spiritual needs were respected. There were photos on display of recent social events that had been held at the home.
The activities organiser told us that they had forged links in the community with a local church and a nearby university. Members of a local church visited the home regularly to support people with their faith. Local students who were studying music also came to the home and ran music therapy sessions with people .We saw a number of recent photos of people taking part in these events. The staff told us both events were very popular with people at the home.

We observed a singing session with people in the home. People were actively participating and from observations evidently had a good relationship with the activities co-ordinator. Staff were seen supporting people to participate and encouraging them to join in the singing session. We observed the activities co-ordinator supporting people by turning pages for then enabling them to keep up with the session. The participants were observed clicking their fingers clapping and singing and appeared to enjoy the music.

There were 'person-centred' boxes in use for people in the home. These were kept in an easily accessible part of the lounges. The boxes had been put in place to assist staff to run activities based on what people enjoyed doing. The boxes contained items which were of interest to the individual. These included books, craftwork, and photos. This idea came from research into individualised care for people with dementia.

People were actively encouraged to make their views known about the service. For example, people were asked for their suggestions for activities and the meal options. Residents and relative meetings were held on each of the units. We saw information displayed on notice boards in each unit that showed how the views of people had been responded to at meetings. People had made for example, specific requests about meals and social activities. These had been acted upon to improve daily life for people.

The home had a newsletter given out on a weekly basis to people at the home and their relatives. The most recent issues included updates on recent events that had happened, dates of meetings and outings as well as major celebrations, festivals and events in the country and around the world.

There was a system in place to respond to complaints. We saw example of concerns that had been reported to the registered manager and it was clear that action had been taken in response. For example, concerns had been raised about the cleanliness of one unit in the home. The action taken included adjusting the cleaning rota and adjusting the housekeeper's hours.

Requires Improvement

Is the service well-led?

Our findings

One relative told us "The home is well-managed in my opinion. I have spoken to the manager but not met her in person yet. I know the senior nurse. If I had any concerns I would speak to Maddie or any of the other senior nurses. I have recommended this home to other people that I know". Another visited commented "I'm impressed with this place. It may not be the closest for our family, but it's the best. As far as I'm concerned, it's great".

There were systems in place to monitor the quality of the service provided. This included regular monitoring visits from staff within the organisation. We saw from records of these visits that actions required to improve the service were identified and responded to. For example, we saw a quality assurance report from March 2017 that identified odours on some units within the home. There was a note on the report to say that action had been taken. During our visit we noted no odours on the units concerned. However, the systems in place were not fully effective and had not identified the breach of regulation found at this inspection. Further audits included a care plan audit and a monthly medication audit. The medication audit had identified issues such as a medicine not being signed for and it had been recorded that the member of staff responsible had been spoken with. However the concerns in relation to medicines found at this inspection had not been identified. This included inconsistent use of PRN protocols, and lack of recording of topical cream administration. Quality and safety monitoring systems had also not identified the inconsistencies in the use of risk assessments and concerns about bedrail heights.

This was a breach of regulation 17 2 (a) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also saw a report from an external organisation who were specialists in dementia care. Although the report had identified some areas for improvement, it was noted that overall the experience was positive and that staff were kind and caring in their approach.

There were two registered managers at the home. One was in day to day charge of the reablement unit, Orchard Grove and the other registered manager was in day to day charge of the rest of the home. The registered managers were supported by staff within the wider organisation. On the day of our inspection, the Head of Clinical Excellence was present. Within the home, there was a structure to support the registered managers, with unit leaders in place for each area of the home. This meant there was clear leadership throughout the home and staff had clear mechanisms for reporting and discussing any concerns or issues.

Staff were positive about working in the home and felt supported in their role. Staff told us communication was good within the team and regular team meetings were held to discuss important issues in the running of the home.

The registered managers were aware of the obligations associated with their role such as ensuring notifications were made when necessary. Notification are information about specific events that the service are required to send us by law. For example, the registered manager had made notifications about

safeguarding incidents, serious injuries and the outcome of DoLS applications as required.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not consistently well managed and administered across the home. 12 2 (g) Risk assessments were not always completed or completed accurately. 12 2 (b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems for monitoring the quality and safety of the service were not fully effective in identifying breaches of regulation. 17 2 (a) (b)