Mr & Mrs T E Dobson

The Bay Tree Residential Home for the Elderly

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**

Overall summary

This inspection took place on 30 April 2015 and was unannounced. At the last inspection on 19 September 2013 we found the service was meeting the regulations we inspected.

The Bay Tree Residential Home for the Elderly provides personal care for up to 18 older people. On the day of the inspection there were 15 people living in the home. The home is located in the picturesque fishing village of Robin Hoods Bay close to shops and cafes. The home has been extended in a style in keeping with the original listed building. It is located in the upper part of the village. It has a garden at the front and a car park at the rear. There is a veranda with seating at the rear which is accessed from the main lounge. The accommodation is spread over two floors, with the third floor for private use by the providers.

The home has a registered manager who is also the owner 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

Summary of findings

'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.

Staff were able to tell us what they would do to ensure people were safe and people told us they felt safe at the home. The home has sufficient suitable staff to care for people safely and they were safely recruited.

Staff had received some training to ensure that people received care appropriate for their needs, however, training was not up to date in mandatory areas such as infection control, health and safety, food hygiene and medicine handling. You can see what action we told the provider to take at the back of the full version of the report. However, people told us and we observed that staff cared for people in line with best practice and they were able to tell us about effective care practice.

Staff had not received up to date in the training in Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) this area. We made a recommendation about this. However, staff ensured that people were supported to make decisions about their care, people were cared for in line with current legislation and they were consulted about choice.

People's nutrition and hydration needs were met. People enjoyed the meals and their suggestions had been incorporated into menus. However, a number of people took all their meals in their rooms. We could not be sure why this happened and we have made a recommendation in the full version of the report that the registered manager assesses the impact on people around this and makes any necessary changes.

People were treated with kindness and compassion. We saw staff had a good rapport with people whilst treating them with dignity and respect. Staff had a good knowledge and understanding of people's needs and worked together as a team. Care plans provided information about people's individual needs and preferences.

People enjoyed the different activities available and we saw people smiling and chatting with staff. Staff made detailed records of people's changing needs. Needs were regularly and thoroughly monitored through daily staff meetings and updates.

People told us their complaints were handled quickly and courteously.

The registered manager was visible working with the team, monitoring and supporting the staff to ensure people received the care and support they needed. The registered manager and staff told us that quality assurance systems were used to make improvements to the service. We sampled a range of safety audits and care plan audits. However, as some audits such as for medicines and infection control were not recorded we could not evidence that they had taken place. We have made a recommendation about this in the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff had not all received up to date safeguarding training. However, staff could tell us how to act if they suspected abuse.

People told us that they felt safe. There were sufficient staff with attention to skill mix and experience to care for people safely.

Staff told us and we observed that they carried out effective infection control procedures.

People were protected by staff who were safely recruited.

Staff had been trained in the safe handling of medicines however, this was not up to date. We observed these were handled safely and staff knew the principles of safe handling of medicines.

Is the service effective?

Requires Improvement

The service was sometimes effective.

Not all staff were adequately trained and supported to meet people's needs. The registered manager had not updated their training to ensure it was in line with current best practice. As the provider then trained staff, they could not in turn be sure they offered training in current best practice, particularly around medicine handling.

Although people had received mental capacity assessments, records did not fully reflected their needs. Also, staff had not received up to date training in this area. However, the registered manager was aware of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and staff knew how to protect people around their mental capacity. People were supported in this area of care by appropriate professionals.

People had access to healthcare services when they needed them.

People were consulted about their meals, their nutritional needs were met and they had access to food and drink whenever they wished.

Is the service caring?

Good

The service was caring.

All staff we observed had positive relationships with people and were reassuring and kind in their approach. Staff were not rushed and always gave people the time and attention they needed.

People were involved in decisions about their care and we saw staff consulting with people kindly.

Summary of findings

People told us that they were treated with respect and regard for their privacy and dignity. We found that care practice respected privacy or dignity.

Is the service responsive?

Good

The service was responsive to people's needs.

Daily notes and monthly updates contained detailed information about people's care needs and how these changed. People told us that the providers and the staff knew them and their needs well and responded to these.

People had stimulation and interest in their lives.

People's concerns and complaint were listened to and acted upon.

Is the service well-led?

Requires Improvement

The service was mostly well led.

There was a registered manager in place.

Leadership was strong and visible however, the quality assurance system was incomplete. There were gaps in the way checks and safeguards in the home were recorded which placed people at risk.

Communication between management and staff was regular and informative. They had daily meetings and staff had sufficient opportunity to consult and gain advice. All staff voices were respected and the staff team worked together to ensure people received the care they needed.

The culture was supportive of people who lived at the home and of staff. People were consulted and surveyed for their views.

The Bay Tree Residential Home for the Elderly

Detailed findings

Background to this inspection

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

This inspection took place on 30 April 2015 and was unannounced. It was carried out by one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

We did not request a provider information return (PIR). The PIR 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 gathered all information on the inspection day because we did not have information from the PIR.

On the day of the inspection we spoke with five people who lived at the home, two visitors, the providers, one of whom was the registered manager and all three members of care staff. After the inspection we spoke with two health and social care professionals about the service.

We spent time observing the interaction between people who lived at the home and staff.

We looked at some areas of the home, including some bedrooms (with people's permission where this was possible) and communal areas. We also spent time looking at records, which included the care records for four people. We looked at the recruitment and supervision records of three members of staff, training records, rotas for the past two months, four care plans with associated documentation, quality assurance information and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe. One person told us, "I feel safe. There's always somebody there to sort me out if I faint or anything." A visitor told us, "Safe? Definitely." They also told us that they thought the home was clean, for example, "It's clean and fresh."

People told us that they though there were enough staff. For example one person told us, "Enough staff? Yes, at all times." Another said, "Oh yes. If I rang that buzzer now, there'd be someone there in two shakes of a lamb's tail." However, one person told us, "Sometimes they're stretched a little bit, could do with one more, for instance you might have to wait with the commode. With the buzzer, there's no wait... Usually quite a good response."

We saw there were safeguarding policies and procedures in place. Staff were clear about how to recognise and report any suspicions of abuse. They were also aware of the whistle blowing policy and knew the processes for taking serious concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively. Staff had received safeguarding of adults awareness briefings in their induction.

Though staff had not received updated training in safeguarding adults, when we spoke with staff they could correctly tell us who they would approach if they suspected there was the risk of abuse or that abuse had taken place. They understood who would investigate a safeguarding issue and what the home procedure was in relation to this.

We asked the registered manager how they decided on staffing levels. They told us this depended on the numbers and dependency levels of the people living at the home at any time, but for the current occupancy of fifteen, there were usually three care workers on duty during the day time, two care workers during the evening and one waking care worker during the night. The registered manager explained that as they lived on the premises they provided a further 'sleep in' back up at night for staff. The registered manager told us they considered skill mix and experience when drawing up the rota. We saw the rota and spoke with staff about this, which confirmed what the registered manager told us. Staff told us there were enough staff on duty to meet people's needs, to chat and not feel rushed. We saw staff were available in the communal areas during our visit.

Risk assessments were in place for each person living at the home. However, these were brief and gave insufficient detail about how risk could be effectively managed. When we spoke with the providers and staff they were able to tell us how they managed risk to ensure people's freedom was maximised while keeping them safe. However, the detail of this was not recorded.

We looked at the recruitment records for two recently employed staff which showed safe recruitment practices were followed. We found recruitment checks, such as criminal record checks from the Disclosure and Barring Service (DBS) and that two references were obtained before staff began work. This meant that the home had taken steps to reduce the risk of employing unsuitable staff.

We looked round the home and found the premises were clean and tidy. There were no obstructions and most areas of the home were accessible by lift. We noted that the lift was a good size and could easily carry a care worker with a person using a wheelchair. For rooms which were accessed by stairs, risk assessments had been carried out to ensure people were not at risk of harm. We saw maintenance certificates were in place and were up to date for equipment and the premises, for example electrical wiring and the lift. Records showed weekly checks were carried out to ensure the safety of the premises such as fire safety. Environmental risk assessments were in place to ensure people were protected.

We saw that entry to the home was controlled and there were keypads on the front and back exit doors for people's safety.

Staff told us that they had received training in the control of infection during their induction, and had received updates during morning meetings with management. Though induction training was recorded, subsequent infection control updates were not. However, when we asked staff about good infection control practice they correctly described how to minimise the risk of infections. They spoke of using sanitising gel, which was available throughout the home, but also told us that they washed their hands frequently and always between offering care to people. The service had an infection control policy and procedure which staff told us they followed. This included details of how to manage outbreaks of infection. We saw that staff used aprons and gloves when they were giving personal care, and that they disposed of these correctly in

Is the service safe?

order to protect people from cross infection. The registered manager told us that laundry was carried out by staff on each shift. Clean and dirty laundry was kept separate to minimise the risk of cross infection.

Medicines, including controlled drugs, were stored securely in a locked room. They were supplied to the home in a Monitored Dosing System (MDS). We found appropriate arrangements were in place for the ordering and disposal of all medicines. The home had recently been given advice on the safe administration of medicines from the local authority and the registered manager had followed this. The lay out of the home meant that it was difficult for the medicines trolley to access certain areas of the home. Following advice, staff worked in pairs, with one member of staff staying with the trolley while another member of staff completed the full task of preparing medicines, administering them and signing for them. This eliminated the risk which the previous system raised, where the same member of staff did not always oversee the full preparation and administration process. This meant that people were protected from the risk of error in medicine administration.

Staff were patient and calm when administering medicines to people. They explained to people what the medicine was for, why they needed to take it and stayed with each person until the medicine had been taken. However, staff sometimes recorded that a medicine had been administered immediately before this had actually happened. This meant there was a risk that recording would not accurately reflect what medicines had actually been taken.

We looked at the Medication Administration Records (MAR) for four people. The MARs were well completed and medicines were signed for, which indicated people were receiving their medicines as prescribed, and any refusals or errors were documented. We looked at the records and checked the stock levels for one person who was prescribed controlled drugs and found these were correct.

Staff told us that they received regular medicine training updates. However, this training was carried out by one of the providers and there was no evidence that their medicine training had been recently updated, also the training was not recorded consistently. This meant there was a risk that training would not take account of best practice in medicines handling. The manager told us they audited all medicines every day to ensure that they were stored correctly and so that they could immediately address any errors in recording. However, these audits were not recorded. This meant we could not evidence that that people were protected by regular medicine audits.

We recommend that the provider ensures staff always record medicines at the correct time to protect people from errors in administration.

We recommend that the provider records how risks are managed so that people can be protected from harm and live their lives with as little restriction as possible.

Requires Improvement

Is the service effective?

Our findings

Staff had received training in all mandatory areas during induction. Induction records contained information about how staff were introduced to the service, these were thorough and covered all required areas. Staff told us they shadowed other more experienced staff when they were first recruited and only began working with people unsupervised when they were confident and the registered manager felt they were competent. Staff had received training in dementia awareness and they told us this was very useful in understanding the challenges facing some of the people who lived at the home. A number of staff had achieved the national vocational qualification (NVQ) at level three and two, which meant they had covered all mandatory areas of care within this training. They had also received regular training in moving and handling, first aid and fire safety. However, other mandatory training had fallen behind and staff had not all received up to date training in safeguarding adults, health and safety, infection control, safe handling of medicines or food hygiene. The registered manager had not updated their training in these areas. This meant people were at risk of receiving care which did not meet their needs.

This was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that any decisions are made in people's best interests.

The registered manager told us that one referral been made to the local authority for assessment about deprivation of liberty safeguards. They recognised that they had not at first fully grasped the implications of the Supreme Court ruling around deprivation of liberty in care homes, however, the registered manager had discussed the care of all people who lived at the home with the local authority and were in the process of making referrals.

Staff we spoke with told us they had not received specific training about the MCA and DoLS. There was brief information on files about people's capacity to make decisions about their care but these did not provide meaningful guidance for them on how to offer care which supported people adequately in relation to their mental capacity. Care plans did not sufficiently take into account how and when capacity may vary or what could be put into place to maximise people's control over their lives. However, the risk to people was reduced because staff were able to demonstrate that they understood how to treat people with regard to their mental capacity and were able to give examples of how they did this with people who lived at The Bay Tree. For example they spoke about how people may have the capacity to make some decisions and not others, that they may have the capacity at some times and not others and that they should always begin by assuming capacity and supporting people to make their own decisions where possible. They were able to explain when a Best Interests decision would be made and who would be involved in such a decision. (A Best Interests decision is made when a person is assessed to lack capacity to make a decision for themselves and involves a multidisciplinary team). Staff told us that they always sought people's consent before offering care. We observed staff explaining the care they were giving and asking people for their agreement. A health and social care professional confirmed that the registered manager consulted with them appropriately for support around Best Interests decisions and mental capacity.

People told us they were enabled to make decisions about their lives. One person told us, "You have a lot of control over things – I decide what I want to do. They treat me as a human being. I don't think it could be better. It suits me."

People we spoke with told us the food was very good. One person told us, "On the whole, very good… I usually have a tray in my room… The food is hot mostly – just once it wasn't... No, we don't get choice often. It's the same each week but they mix up the days so they don't come too soon. They do a full Sunday lunch." One visitor told us, "'I think the food is very good. It's cooked on the premises."

Needs relating to nutrition and hydration were recorded in care plans and risk assessments. The home had a system of using a red tray for those people who had nutritional vulnerability or who required assistance with eating. Staff told us this acted as a memory aid to ensure people received the assistance they needed at meal times.

Tables in the dining room were laid attractively with paper tablecloths, placemats, cutlery and cruets. Hot meals on trays, and those served in the dining room, were all covered when served to maintain warmth. The food was hot, served

Requires Improvement

Is the service effective?

in good portions and looked appetising. There was no menu available for people to see prior to the meal being served, and there was no choice of main meal. However, people told us that if there was a meal they did not like the chef would approach them individually to ask whether they would like an alternative. The registered manager told us that medical conditions such as diabetes which required monitoring were managed in consultation with health care professionals. Care plans confirmed this.

However, we observed that only six out of the fifteen people who lived at the home ate their lunch in the dining room. A few more ate on portable tables in the lounge but the rest had trays in their rooms. Two people told us that they felt it was "a lot of trouble" for them to go down to the dining room for their meals and had chosen to eat alone. We did not see evidence of the reasons for people not eating in the dining room. This meant there was a risk people would feel isolated in their rooms and miss out on the dining experience.

Induction records contained information about how staff were introduced to the service, these were thorough and covered all required areas. Staff told us they shadowed other more experienced staff when they were first recruited and only began working with people unsupervised when they were confident and the registered manager felt they were competent. Staff had received training in dementia awareness and they told us this was very useful in understanding the challenges facing some of the people who lived at the home.

The care plans we looked at showed people had been seen by a range of health care professionals including GPs, district nurses and chiropodists. We saw from the records that one person had a specific problem and staff had contacted a range of health care professionals to resolve the issue, including the Community Mental Health Team. Staff maintained detailed records of all specialist involvement. We saw care workers had involved the GP in a timely when there were queries about health. Needs in areas such as pressure care, moving and handling and any clinical care needs were recorded in detail. A health care professional told us that the registered manager involved them appropriately and that they followed their advice.

However, some people were not regularly weighed which meant that the home could not adequately monitor if some people lost or gained weight. The registered manager told us that they did not have any scales which could accommodate people who were not able to bear their own weight, nor were any methods employed which might otherwise provide a record of weight, such as measuring arm circumference. This meant there was a risk people would not have their medical needs met in relation to their weight.

We recommend that the registered manager carried out mental capacity assessments where necessary to ensure people are supported to make decisions about their care.

We recommend the registered manager monitors the weight of all people who are vulnerable to weight change, so that their health needs may be met.

We recommend that the registered manager assesses the impact on people's wellbeing when they remain in their rooms at meal times.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring with them. One person told us, “They’re very, very kind. Sometimes staff have a chat if they’re not busy. They will listen to you.” Another person told us, “The Manager comes round with pills each morning and asks “What sort of a night have you had?” Another person told us, “At night, if I fall asleep with the TV on, they come and check and turn it off. They are really excellent.” A visitor told us they could visit at any time and felt very welcome, “They’re lovely people and they keep making me a cup of tea.”

We spent some time with people in a communal area and observed there was a relaxed and caring atmosphere. People were comfortable and happy around staff and there was kindness between them as they chatted. We saw that staff encouraged people to express their views and listened to their responses. Staff gave the impression that they had plenty of time and were respectful in their conversations with people. Throughout the visit, we saw that all staff knew people, their likes and dislikes and their relatives and friends very well. We saw all staff address people by name in a kindly manner.

A number of visitors called during the day and they were welcomed warmly by staff who clearly knew them well. Visitors were offered refreshments and we heard staff giving visitors an update on their loved one’s well-being.

Some people were able to express their views clearly but there were others whose voices may not have been so easily heard. The staff made efforts to make sure these people’s views were heard and acted on. For example, staff spent time with those people who had difficulty expressing themselves due to cognitive impairment to ensure their wishes were listened to. We saw that staff often re approached a person who was feeling upset, to calm them and offer reassurance. They discussed with the person and each other what may help to make them feel more at ease. Staff told us they had time to visit people in their rooms and chat so that they did not feel isolated.

Staff spoke with enthusiasm to us about how they could improve the experience of care and compassion for people. They talked about going out for visits and encouraging relatives and friends to visit so that the atmosphere within the home was homely and inviting.

Good

Is the service responsive?

Our findings

People indicated to us that the service was responsive to their care needs. For example, one person told us how they could choose when they had a shower and that they preferred this to a bath.

We found that staff gave care in a personalised way. Some of the people we spoke with told us that they had worked with the registered manager and senior staff to draw up their care plans. Those who had not looked at their care plan told us they did not wish to look at these because their needs were met. People told us that reviews took place in consultation with them when risk levels changed.

Where people had the capacity to do so, they gave us a clear account of the care they had agreed to, some had signed care plans and we saw that written plans were regularly reviewed with people's involvement.

People had identified areas of interest within their care plan, though records were brief in this area. However, people told us they were well supported to pursue their interests. The registered manager told us: "We try to let people do their own thing." One person told us that they got up and went to bed when they chose to. Another person enjoyed doing jigsaws. We saw a jigsaw out on a table and partially completed. A care worker told us that they had given some people hand massage and nail care the day before. When we spoke with people they confirmed this. One person told us they kept busy, "I read and do crossword puzzles and watch TV. I often go down for entertainment. A man comes on a Sunday once a month (for music entertainment). A clergyman comes occasionally." Another person told us, "I've started writing a crime novel." Another person told us, "I knit. I've been knitting for premature babies in Scarborough Hospital and James Cook Hospital in Middlesbrough. I'm never lonely." They also told us that the providers had recently organised a special birthday party with a buffet lunch. "Thirty of my relatives came. It was very nice. All the residents joined in."

The registered manager told us that they were recruiting for an activities organiser but that they currently offered people interesting things to do between the staff team. Staff told us that they offered memory work, crafts, games and music to people in the afternoons. People told us that they played dominoes, and enjoyed art and craft work. They mentioned that they went out for walks to look at the sea and to local cafes and fetes and were looking forward to the 'Tour de Yorkshire', where they planned to go out and watch the bikes which would pass close by. We noted that there was a rummage box available in the main lounge which had been provided for the particular needs of one person and contained objects of interest them. This was responsive to this person's needs.

Daily reports were detailed. Staff recorded information three times a day about people's well- being, activities they had engaged in and any concerns. Night reports were also detailed with relevant and helpful information about people's care. This meant staff had information to help them to offer care which was responsive to people's changing needs.

Reviews were also thorough. Staff used a detailed narrative which placed the person at the heart of the process. Reviews focused on well- being and any improvements which could be made to people's health and well-being. Relevant specialists were consulted for advice at these reviews. Monthly updates were recorded by keyworkers and again these were detailed and contained useful and relevant details to assist staff to plan responsive care.

Staff could tell us about people's care needs and how these had changed. They explained how referrals to nurses and mental health professionals had been made following reviews to ensure care remained appropriate for each person. They described how they could interpret body language and facial expressions to understand how people were feeling and whether they agreed to care. One member of staff explained how a particular approach using music and talking about particular subjects such as horses helped to calm a person when they became upset.

People told us they would feel confident telling the staff if they had any concerns and felt that these would be taken seriously, though all told us they had never made any formal complaints. Staff told us that they encouraged people to speak up if they had any concerns and confirmed that people were confident to do so. One visitor told us, "I would go to the manager for a complaint (and) I would speak to staff. We've had no problems at all." Another person told us, "I would speak to one of the carers initially." The service had a complaints procedure and the registered manager told us they followed this to ensure people's complaints were appropriately dealt with; however, there had been no recent complaints.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with told us they thought the home was well run. One person told us,

"It always stems from the top. The manager pops in and I could ask to see him any time." When asked if they would recommend the home one person told us, "I would, yes." Two other people we asked agreed. Another person told us, "'I see the manager daily except Tuesday."

Visitors told us that they often approached the registered manager to chat and to make suggestions and that they were always listened to.

The registered manager was visible in all areas of the home throughout the day. We saw they led by example and provided a good role model for the staff team. They were approachable and worked with the team addressing any issues promptly with staff and praising good care.

All staff met each morning with the manager and they told us this was to discuss each person's care and to pass on any information they needed to know. Staff told us that the culture of the service was focusing on good quality care and to be open and honest about any concerns. We observed that the culture was inclusive and put people at the heart of care. Staff told us they were encouraged to ask questions and to offer suggestions about care and that the registered manager took these seriously and acted on them when possible. Staff told us that they understood the scope and limit of their role and when to refer to another person for advice and support.

There were some systems and procedures in place to monitor and assess the quality of the service. For example we saw records of checks such as emergency lighting, fire equipment and lift servicing. Each day one of the providers walked around the building to check on infection control practice, general cleanliness and any repairs which needed to be done. They then discussed this with the registered manager who would arrange for maintenance work to be carried out. The registered manager told us that because the premises were not large this method of checking the environment worked well. Staff told us that the registered manager discussed infection control, care planning, and changes in care needs with them at the daily morning meeting. One of the providers told us that they audited medicines each day and fed back any discrepancies to staff on the same day or when they were next on shift. However, there was no record of medicine audits which meant it was not possible to evidence that these audits took place. Neither were there audits for infection control which meant it was not possible to fully evidence that people were protected by these checks.

The registered manager told us that they consulted with people regularly on a one to one basis and people confirmed that this was the case. For example, people told us about outings which they had requested and that the manager had arranged. We saw surveys which had been carried out with people and staff told us that they had discussed the results of these in staff meetings. The registered manager explained how they had made improvements to people's care based on results from surveys. For example, with regard to activities and meal choices.

The registered manager worked well in partnership with health and social care professionals to ensure people had the benefit of specialist advice and support. Daily notes and monthly updates contained detailed information about how advice was to be incorporated into care practice. Health and social care professional told us that they were consulted and that the registered manager worked well with them.

We recommend that the registered manager records audits in key areas to ensure care practice is appropriately monitored, may be shared with staff and improved for people's benefit.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff did not receive appropriate training to enable them to carry out their duties.**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.