R C Care Rosehill Ltd

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Inspection report

Robins Hill
Raleigh Hill
Bideford
Devon
EX39 3PA

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29 September 2020
13 October 2020

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
R C Care Rosehill Limited is a residential care home and is registered to provide personal care to up to 17 people, including those living with dementia. At the time of inspection there were 16 people living at the service.

People's experience of using this service and what we found

People were at risk of avoidable harm and unsafe care.

Risks to people's health, safety and welfare had not always been identified, assessed or managed. Where risks had been identified, they were not regularly reviewed, and appropriate action was not always taken to address them, including a delay in seeking medical advice.

Peoples care records did not contain enough information to enable staff to support them effectively. Staff did not have training in how to use equipment safely, or how to manage individual's health conditions.

Staff were not always recruited safely and had been allowed to work at the service without the required pre-employment checks. There had been a significant staff turnover, and new staff were inexperienced and had yet to receive appropriate training. There were occasions where there were not enough staff to meet people's needs, and the home did not consider peoples individual needs when deciding staffing levels.

People told us they felt safe living at the home, however safeguarding incidents were not always referred to the local authority or the Care Quality Commission. Staff told us they knew how to recognise signs of abuse but had not had safeguarding training. This put people at risk of abuse and neglect.

People did not always receive their medicines safely. Systems to ensure people received the right dose of medication were not robust and people did not always receive newly prescribed medication in a timely manner. Some improvement to record keeping was needed, for example where people were receiving non-prescribed medications on a regular basis.

The premises did not always keep people safe. One person regularly left the building when unsafe to do, which put them at risk of harm. A safeguarding concern had been raised previously, however the action taken as a result of that concern was not effective in preventing the person continuing to leave the building.

A lack of analysis of safety and safeguarding incidents meant lessons were not learnt when things went wrong. Following this inspection, we raised two individual safeguarding concerns.

We have signposted the provider to resources to help develop their approach to preventing and controlling infection.

The registered manager had made some positive changes to the service, and people told us they were happy, however, there were significant shortfalls in service leadership. Quality assurance reports and action plans provided to the Care Quality Commission following the previous inspection failed to identify or address the concerns we found at this inspection.

Audit and monitoring systems were inadequate. Information was not analysed, and the provider did not undertake any quality control audits or checks. Many people had been admitted to the service during a period where the registered manager was new to post, there was a high staff turnover and the home faced the challenges of the early stages of the Covid-19 pandemic.

The lack of quality assurance systems and analysis of current performance meant the service was not continuously learning or driving improvement. Current best practice and information was not being used to improve quality.

There was limited partnership working with other agencies, and records did not demonstrate an open sharing of accurate information or a good understanding of where partnership working might be beneficial to people.

People and their families told us the registered manager was caring and improvements had been made to the atmosphere, culture and approach of the home. However, there were still indications of people fitting into routines to suit the staff, and times where staffing levels did not enable people to receive care at the times that suited them.

People and the public were not consulted or engaged in how the home was run.

Following the inspection, we held a feedback meeting with the provider and the registered manager to discuss our concerns. The following day we were informed the registered manager had handed in their notice and would be leaving the home imminently. The provider has informed us of interim management arrangements until a new manager is in post.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for the service under the previous provider was requires improvement (published 28 August 2019) and there was one breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve systems in place to monitor, audit and improve the service. At this inspection, not enough improvement had been made and the provider was still in breach of this and five further regulations.

Why we inspected

We undertook this focused inspection to check the service had completed their action plan from the last inspection and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions safe and well-led which contain those requirements.
The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for R C

Care Rosehill Ltd on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, recruitment, fit and proper persons employed, staffing, safeguarding, good governance and statutory notifications.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor the service through ongoing monitoring, seeking an action plan, special measures and working with partner agencies. We may inspect sooner if required.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Inadequate

Is the service well-led?

The service was not well led.

Inadequate

R C Care Rosehill Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the home under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the home in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two Inspectors completed the Inspection.

Service and service type
R C Care Rosehill Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
The home had two managers who were both registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the home is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was announced.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their home, what they do well, and improvements they plan to make. This information helps support our inspections.

We reviewed information we had received about the home since the last inspection. We also reviewed

information the provider sent us including their monthly action plans which were required as part of their condition of registration. We sought feedback from the local authority and social care professionals who work with the home.

We used all this information to plan our inspection.

During the inspection
We spoke with eight people living at the home and observed how staff supported people. We spoke with twelve staff, including the registered manager on duty, care staff, ancillary staff, and two health professionals.
We reviewed a range of records. These included three care records, four staff recruitment files, maintenance records, audit tools and quality assurance systems. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We spoke with the nominated individual who is also one of the registered managers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection
We continued to evaluate records and requested further information from the provider. This included care records and management information. We spoke with three family members of people living at the home, and two health professional who regularly visit the home.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Premises

- People were not safe because risks to their health, safety and welfare had not always been identified, assessed and managed.
- For example, one person had lost a significant amount of weight in a short period of time. It had been several weeks before the home acted to address this, during which time the person continued to lose further weight and became severely underweight.
- Where risk assessments were in place, these lacked detail and had not routinely been reviewed or updated. For example, two people were able to leave the building on multiple occasions, when it had been assessed it was unsafe for them to do so unaccompanied.
- People's care records did not contain enough information for staff to support them to stay safe. For example, one person's care records lacked information relating to the management of their health condition. A visiting health professional told us they had recently found the person to be showing signs of a deterioration in their condition, which put them at risk. Staff had not recognised these signs and therefore not taken any action to reduce the risks of poor health outcomes.
- Another person needed the use of a hoist to move at all times. They had an air mattress in place to prevent pressure damage to their skin as they were immobile. Their care records lacked any information about how to safely use this equipment, and staff told us they had not received the necessary training to do this safely. There was no information to tell staff what setting the air mattress should be on, in relation to the persons weight, and this put the person at unnecessary risk of pressure damage to their skin.
- This was discussed with the registered manager. They told us this person's bed was set for an 'average' person. However, this person was noted to be underweight and had recently shown the early signs of pressure damage to their skin. This put them at risk.
- Records showed some hot water reached excessive temperatures. Water in a bathroom on the top floor was recorded at 50 degrees for the previous year, and no action had been taken to resolve it.

Using medicines safely

- Medication records showed that people did not always receive their medicines as prescribed.
- For example, one person was taking a medicine to thin their blood. They required regular blood tests by community nurses to make sure the person was receiving the right amount of medicine. The home did not take prompt action when the blood test was missed. This meant they did not know what dose of medication the person should have received, which put the person at risk.
- There were incomplete records relating to this medicine and changes in dosage were not recorded on the

medication administration record (MAR). They were kept on a piece of paper which was unclear and did not have the person's name on. These were then disposed of and not kept as a stored record so there was no audit trail of the amount given.
●There were gaps in the MAR because medicines in stock were not being checked.
●Some people used a skin patch for pain relief. There were incomplete body maps to show which areas of the body these should be applied to.
●Several people had prescribed creams for their skin. However, there was no guidance to instruct staff where to apply these creams and on what area of the body for which cream.
●Where people had over the counter medicines, it was not clear what these were used for. For example, one person had received pain relief four times a day for over two weeks. They had not been referred to the GP for a health review and the MAR did not state why the person had been given pain relief for over two weeks.

The provider failed to assess the risks to the health and safety of people and do all that is reasonably practicable to mitigate any risks and failed to ensure people received their medicines safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●On the second day of the inspection, we found some improvements had been made to peoples care records. However, this information was not complete and had not been communicated to staff. For example, the cook did not know how to effectively support a person whose care records indicated they needed additional support to gain weight. A plumber had been contacted again to look at the issues regarding the very hot water.

Staffing and recruitment
●People living in the home were not safe because the registered manager had failed to recruit staff in line with legal requirements and the providers procedures.
●Recruitment records of three new staff appointed were incomplete. Missing or incomplete documents included application forms, suitable references, gaps in employment history and interview notes. There was little information about people's previous employment history, which meant references could not be validated.
●One staff member had recently left the home. This staff member had been employed as a senior care worker, in charge of a shift and other care workers and in charge of the whole service in the registered manager's absence.
●There were no robust references obtained, no complete Disclosure and Barring Service check (to ensure prospective staff are safe to work with vulnerable people), no interview notes and no completed application form for this staff member. There were gaps in employment which had not been discussed. This new employee had been left in charge of the service on one occasion. Following this, they were dismissed from the service following a safeguarding concern regarding missing medication. Had a suitable recruitment procedure been in place, this may have avoided people being put at unnecessary risk from a staff member.

The provider failed to ensure suitably qualified, competent, skilled and experienced staff were employed. This was a breach of regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●There were not always enough staff on duty to meet people's needs fully. The registered manager told us there were three staff on the morning shift, three staff on the afternoon shift and one waking and one sleeping staff members on duty through the night.
●Duty rotas from previous weeks showed there were several occasions where there were only two staff on

duty to meet people's needs.

●One person required the use of a hoist and support from two staff. This meant when there were only two staff on duty and they were supporting this person, there were no staff in the communal areas to observe people. This was also a concern when the day afternoon staff had to serve people their tea and were in the kitchen.

●During the inspection, on one occasion the whole staff team sat on their break together in the dining room. This meant there was nobody to supervise people in the communal area or support them if required.

●The dependency tool used to decide how many staff were needed to meet people's needs did not take account of any care needed outside of getting up, going to bed and mealtimes. It did not accurately reflect the assistance people needed. For example, the dependency tool showed all but one person requiring 30 minutes assistance per day with eating meals, where as some people needed more assistance, and some were able to eat independently.

●Staff said, "You very rarely get to sleep on the night sleeping-in shift as you are needed" and "We have been short staffed sometimes due to people being off sick."

●Two people commented, "There has been staffing problems but I'm quite happy" and "We have been grossly understaffed and the staff they have now are so young and inexperienced."

● The registered manager told us there had been a significant turnover of staff recently. This had resulted in many staff being new in post with some of them with little or no previous experience. Some of these staff had not had the necessary training since they began their jobs, for example how to move people safely and how to keep people safe.

The provider failed to ensure suitably qualified, competent, skilled and experienced staff worked at the service. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Systems in place did not protect people from the risk of abuse or neglect. This was because the registered manager had not always notified the local authority safeguarding team of safeguarding incidents which had taken place at the service. For example, there were multiple occasions of two people leaving the building unaccompanied, when they were assessed as unsafe to do so. Of 15 recorded instances of people leaving the building unaccompanied between 1 April 2020 and the date of inspection, only one was reported to the local authority safeguarding team.

●Staff knew how to recognise the signs of abuse and how to report it. One care worker said, "I would go straight to the registered manager and outside the service if needed." "However, not all staff had received the necessary training as they were new to the service. Three staff on duty at the time of inspection had not undertaken this training to keep people safe. They told us this was planned as part of their induction. One care worker said, "I have been here five weeks and have had no (safeguarding) training." Another said, "I have had no training but where I used to work it was strict (safeguarding) training every six months."

●There was an updated safeguarding policy and procedure in place. This was an extensive document which was long and difficult to find the key information required, for example a flow chart to guide staff on what they needed to do.

●We discussed this with the registered managers who agreed and confirmed they would amend it as soon as possible. The policy had been amended by the second day of inspection, however the updated version did not follow local authority procedures.

●Following the inspection, we made two safeguarding alerts to the local authority safeguarding team relating to two people's safety. A third safeguarding alert was made by a health care professional relating to one person's use of medicines.

●At the time of inspection, these were still being investigated by the local authority

The provider failed to ensure systems and processes were in place to keep people safe from the risk of abuse. This was a breach of Regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●All the people we spoke with told us they felt safe living at home. People were happy, relaxed and cared for. Peoples families told us they felt their loved ones were safe and the home had been "absolutely marvellous".
●People knew if they had any concerns they would speak with the registered manager. During the inspection, people confidently approached the registered manager to ask questions and seek reassurance.

Learning lessons when things go wrong
●There was insufficient analysis of safety and safeguarding incidents, meaning lessons were not learnt when things went wrong. For example, one person fell 28 times during May 2020, there was no analysis of any trends or patterns to address this.
●Other health care professionals and specialists were not involved in reviewing peoples care when things had gone wrong, and there was a lack of clarity about what information had been shared. For example, one person had a very high number of falls in the first three months they lived at the home. The registered manager told us the person had been reviewed, but could not tell us who by, or what the outcome of that review was.
●Where there were records of incidents taking place, there was no analysis of these incidents and no guidance provided to staff as to how to reduce the risk of the same thing happening again.
The provider failed to ensure systems and processes were in place to assess, monitor and improve the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was accessing testing for people using the service and staff.

We have also signposted the provider to resources to develop their approach.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to have adequate audit and monitoring systems in place to improve the service and records relating to the running of the service. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 17.

Following the inspection, we were informed that the registered manager had handed in their notice and would be leaving the service imminently. In the interim, the nominated individual, who was also a registered manager, would be managing the day to day service until a new manager started in post

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

●The registered managers did not ensure quality performance, risk and regulatory requirements were met. Following the last inspection, we imposed a condition requiring the provider to submit a report to the Care Quality Commission each month that set out the actions taken, or to be taken, as a result of audits and quality monitoring processes undertaken.
●These reports showed quality assurance processes had been carried out. However, these had not been effective. The systems failed to identify issues, or if identified failed to rectify them. For example, in September 2020 the provider informed us ten per cent of care plans had been checked using a care plan audit tool and "all care plans reviewed and updated as required". We found that no audit tool had been completed and there were significant gaps and omissions in peoples care records and risk assessments. The lack of systems and processes in place to identify concerns or shortfalls within the service placed people at increased risk.
● Following the last inspection, we also imposed a condition that limited the amount of people the registered provider was permitted to admit to the home. This condition expired on 1 March 2020. It was imposed to ensure the service did not admit too many people too quickly while the home improved. Between 1 March 2020 and the date of inspection 18 people were admitted to the home. This was during a time that the registered manager was new in post and the home was experiencing a high turnover of staff while dealing with the complexities of delivering care during the early stages of the Covid-19 pandemic. The decision to continue to admit people to the home at pace in these circumstances put people at unnecessary

risk of not having their care needs fully met.
●Investigations and auditing of incidents and accidents was not robust, fully completed or managed appropriately to mitigate any future risks to people. For example, in September 2020 the provider identified There had been 12 occasions where people had fallen since their last report, however this information was not analysed to identify themes and trends in order to manage the risk.
●The provider failed to ensure there were effective and competent management arrangements in place. They had a lack of oversight of how the service was being run and did not ensure adequate monitoring systems to identify significant shortfalls within the service.
●The registered manager did not fully understand their responsibilities. For example, 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). Records regarding Best Interest Decisions were not clear, and the registered manager did not fully understand their responsibilities under DoLS.
●During the inspection the atmosphere was chaotic. The inspectors spent considerable time waiting for the registered manager to locate records which either did not exist or could not be found. Some sensitive records were not stored securely at the premises but had been taken home by the registered manager.
●The provider is required to display on their website details of the Care Quality Commissions website, the most recent inspection rating and the date it was given. On the first day of inspection we advised the provider they were not currently meeting this requirement. After the second day of inspection this information was still not being displayed.

The provider failed to maintain adequate audit and monitoring systems in place to improve the service and records relating to the running of the service. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
●The service did not recognise where partnership working with others was required. For example, when one person lost a significant amount of weight, they did not take action in a timely way to involve the persons GP. When they did contact the GP, records did not demonstrate that accurate information was provided to inform the correct decision making.
●We asked the provider to contact the persons GP to clarify the information provided and advice given. The registered manager subsequently provided the Care Quality Commission with documentation detailing the advice from the GP. However, they had not read this information themselves and the person was still not being offered their nutritional supplements 19 days after the GP had prescribed them.
●Where the registered manager told us there had been partnership working, no records were kept. For example, we were told one person had been assessed for specific moving and handling equipment by an occupational therapist but there was no record of this visit. We asked the registered manager to check the suitability of the equipment and the correct size for the person using it.
● Visiting health care professionals did not always feel confident that staff were responsive to people's needs. For example, one visiting professional was concerned that a person was in pain and had not been given pain relief in a timely way. This meant the person experienced pain for longer than they should have. When they raised this with the registered manager, the conversation became difficult and the health care professional told us that they left feeling frustrated that they were unable to resolve the issue.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

●The culture in the home was not always person centred. People were happy and the atmosphere was relaxed, however there were elements of practice that were not centred on the people living at the home. For example, we saw staff taking breaks together on more than one occasion, which meant communal areas were unsupervised.
●Notes from a staff meeting held in August 2020 stated, 'we would like (people) to be up to their rooms at 10pm and woken up at 7am', which suggests people were not given individual choice about when to go to bed and when to wake up. A staff member told us 'At 7pm everyone wants to go to sleep and there are not enough staff', which meant people had to wait to have their needs met.
●Another comment from the staff meeting was not person-centred or positive and referred to a person as 'being demanding'. The record further stated the person needed to be reminded 'they can do lots of things them self' without specifying what they needed support with.
●We received mixed feedback from people living in the home. One told us "People are treated well, all the service users are happier, more relaxed and it's more homely", another person said "I'm comfy, but not particularly happy, the atmosphere has changed". Relatives told us the registered manager was 'caring, really nice' and that they felt able to raise any concerns.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
●The registered manager did not always inform peoples families about their health or incidents which had put them at risk.
●Peoples relatives told us that they were kept up to date with their relatives care by accessing the electronic care planning system. However, the service did not always contact them directly when there was an incident. For example, one family member told us they had not been told when an ambulance was called for their family member, and that this frustrated them.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●People were not consulted or engaged in how the home was run.
●We were told that quality assurance surveys had been issued shortly before this inspection.
●Care records demonstrated some limited information had been sought from people and their families about people's life histories, likes and dislikes.
●Minutes from staff meetings did not demonstrate an inclusive culture, for example, one record said 'ask (the registered manager) before moving furniture'.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider did not notify the Care Quality Commission of incidents that it should have done. Regulation 18(1)(2)e

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure systems and processes were in place to keep people safe from the risk of abuse. Regulation 13(1)(2)(3)(6)d

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure suitably qualified, competent, skilled and experienced staff were employed. Regulation 19(1)a,b(3)a

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure suitably qualified, competent, skilled and experienced staff

worked at the service.

Regulation 18(1)

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess the risks to the health and safety of people and do all that is reasonably practicable to mitigate any risks. The provider failed to ensure people received their medicines safely. Regulation 12(1)(2) a,b,c,d,e,g,i

The enforcement action we took:

We issued a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems and processes were in place to assess, monitor and improve the service. Regulation 17 (1)(2)a,b,c,d,f(3),a,b This is the fourth consecutive inspection where we have found a breach of this regulation.

The enforcement action we took:

We continued a Condition of Registration.