Sonrisa Care Limited

The Gables

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Gables is a residential care home providing accommodation for persons who require personal care for up to 24 people. The service provides support to older people. At the time of our inspection there were 21 people using the service. Accommodation is split across 3 floors accessible by a lift, stair lift and stairs.

People's experience of using this service and what we found
People told us they were happy and had their care needs met by care staff who knew them well. However, we found people had not always been provided with safe care and treatment due to a lack of robust systems and processes. This meant people had been placed at risk of harm.

Staff did not have a clear system to follow to report incidents of actual, or potential, harm. Reportable incidents had not always been referred appropriately to the local authority safeguarding team to ensure external scrutiny of the home. There was not a lessons learned process in place.

People had not always been assessed for risks to their health, safety and welfare. Staff had not always identified when a person was at risk, and this meant they had not always adopted measures to prevent the person from being harmed.

People prescribed high risk medicines such as blood thinning medicines, or sedative medicines, had not been assessed to identify any risks posed to them from taking this type of medicine. Medicines had not always been managed safely and this had put people at risk of not having medicines as prescribed.

The home was clean on the days of our inspection, however, systems to ensure people were protected from the spread of infection were not always robust. Assessments to identify people at increased risk from infections had not always been completed and checks to ensure people were safe from the spread of infection had not always been completed.

People were not always supported to have maximum choice and control of their lives and records could not demonstrate staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The home supported people living with dementia however, the adaption and design of the building did not follow best practice guidance to ensure people living with dementia could orientate themselves to their surroundings. We have made a recommendation to the home in regard to the environment for people who are living with dementia.

Governance systems were not robust. The inspection identified five breaches of regulation as systems and processes were either not in place, or not robust enough, to ensure people's care needs were identified and people received safe care and treatment.

Staff had been recruited safely into the service and there were enough staff to meet the needs of the people living at The Gables. People and relatives were complimentary about the staff. We received comments such as, "the carers are great, they need a raise!", "I'd recommend this home, they look after me well" and, "staff help me when I need it, I would recommend this home."

People told us how much they enjoyed the food. People had plenty of choice and people's dietary needs were catered for.

People, relatives, visitors and healthcare professionals spoke positively about the registered manager of the home. One relative told us, "[Registered Manager] sprinkles her love everywhere she goes."

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

Rating at last inspection
The last rating for this service was good (published 23 November 2018

Why we inspected
We received concerns in relation to the safe care and treatment of people and the governance of the home. As a result, a decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led only.

The inspection was prompted in part by a notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls and health deterioration. This inspection examined those risks.

In response to our findings, the provider sent CQC an action plan of immediate actions they intended to make to ensure The Gables was safe for the people living at the home, we were unable to assess whether these changes have been effective and sustainable during this inspection.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to the need for consent, safe care and treatment, safeguarding people, good governance and training for staff.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

The Gables

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 service under the Health and Social Care Act 2008.

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 service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 4 inspectors.

Service and service type
The Gables is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Gables is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 6 November 2023 and ended on 15 November 2023. We visited the location's home on 6 November 2023 and 9 November 2023.

What we did before the inspection
We reviewed information we had received about the service since our last inspection and sought feedback from the local authority. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with 10 people who used the service and 5 relatives about their experience of the care provided. We spoke with 8 members of staff including the area manager, registered manager, deputy manager, senior care staff, cook, housekeeping and care staff. We reviewed a range of records, these included 9 people's care records and 9 people's medication records. We looked at 2 staff records in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
- Robust safeguarding systems and processes had not been established to protect people from the risk of abuse.
- Incidents of harm and potential harm had been recorded by staff in people's daily notes however, we found action to reduce the risk had not been taken. Senior staff had not always been made aware of incidents and when they had, incidents had not been investigated or actions taken to safeguard the person from harm.
- Incidents that had not been appropriately acted on included, 1 person hitting another person, unwitnessed falls where the person sustained an injury and a medicine error involving a high-risk medicine.
- Local safeguarding procedures had not been followed and the local safeguarding team had not been made aware of these incidents. Failing to notify these incidents had meant external scrutiny was not possible to ensure all practical steps had been taken to mitigate risks of harm to people using the service.
- The home did not have a robust and effective lessons learned process in place. This meant learning could not take place and placed people at further risk of incidents reoccurring.

People had been harmed or placed at risk of harm without external scrutiny of the home. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We discussed our concerns with the registered manager and area manager who sent us an action plan with immediate actions they planned to put in place to improve the home.
- We informed the local authority safeguarding and improvement teams who provided assistance to drive improvements at the home and ensure people were safe.
- People told us they felt safe living at The Gables cared for by staff who know them well. Comments from people included, "I feel safe here because the staff listen to me", "yes I feel safe, when I'm a bit wobbly staff are there when you need" and, "yes I love it here, the staff are nice and friendly, and we get everything we need."

Assessing risk, safety monitoring and management
- People had not always been protected from avoidable harm. The risks to people's health, safety and welfare had not always been assessed. We reviewed 9 care plans and found assessments had not always been completed to assess the risk of falls, skin integrity, nutrition or oral hygiene.
- The cause of unexplained marks including bruising, skin tears and changes to the person's skin had not always been explored. Body maps had not been completed, incidents had not been reported and investigations had not taken place. This meant staff could not monitor the person's for any deterioration or

signs of potential abuse.
● A person with a diagnosis of diabetes did not have assessments, or guidance, that identified any potential risks of harm and instructed staff how to support the person to reduce the likelihood of them becoming unwell.
● Inspectors were not asked to sign in when they arrived on the first day. This was brought to the attention of the registered manager and on the second day inspectors were asked to sign in. The signing in book had not been completed by a visitor since 24 January 2023. One relative told us, "No, I've never been asked to sign in." This meant the home could not be certain who was in the building and in case of an emergency would not be able to provide full details of who was in the building to emergency services.
● The home was split across three floors accessible by a lift, stair lift or stairs. Staff told us some people walked around the home for most of the day and records showed people walked and used the stairs independently. We were told, by the registered manager, risk assessments had been completed to identify any risks to people using the stairs. However, we were not able to find any in either the environmental risk assessments, or in people's individual care plan folders. This meant risks had not been identified and people had been placed at risk of harm.
● The environment was not always safe. We found one radiator had not been covered and a sharp metal pipe was exposed, in areas where people walked independently, putting people at risk of harm.

People had been placed at risk of avoidable harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed our concerns with the registered manager and area manager who sent us an action plan with immediate actions they planned to put in place to improve the home.
● We informed the local authority safeguarding and improvement teams who provided assistance to drive improvements at the home and ensure people were safe.

Using medicines safely
● Medicines had not always been managed safely. Staff had not always been provided with instructions to know when to administer as required medicines. A staff member told us, "People will tell you when they are in pain, we ask [medicine trained staff] for their pain relief medicines but they won't get the medicines outside of the medicine round times." This meant people were at risk of being in pain longer than they needed to be.
● The home had not always followed best practice guidance to reduce the likelihood of harm from the administration of medicines. Staff had not been provided with instructions and guidance to ensure all reasonable steps had been taken before they administered as required sedative medicines to people. This meant people were at risk of being restricted unnecessarily.
● Staff had not always recorded what time the as required sedative had been administered. For 1 person who was prescribed up to 2 doses a day, this meant the home could not ensure an appropriate gap had been left in between both doses of medicine and this had placed the person at risk of harm.
● Medicines that were no longer in use had not always been returned to the pharmacy. We found a box of antipsychotic medicine with tablets still inside accessible to staff in the medicines trolley. This medicine was not found on the person's medicine administration record, the registered manager told us the person had not had the medicine for a long time and it was no longer required. This meant there was not sufficient oversight to the stock level, and this placed people at risk of receiving medicines they were not prescribed.
● Records to show applications of creams did not show where or how they needed to be applied. Staff had not signed to confirm creams had been applied as prescribed.
● There was an over stock of eye drops, eye gels and nasal sprays in the medicine trolley accessible for use by staff. Open dates had not been recorded and it was unclear which ones were currently open and in use. 1

person had 2 open eye gels with no open dates, the instructions stated the gels should be discarded within 30 days after first opening this meant the person was at risk of receiving out of date medicine.

People had been placed at risk of harm from medicines that were not managed properly and safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection

● The home was found to be mostly clean in communal lounges and bathrooms on the days of our inspection, however systems had not been established, or operated effectively, to ensure risks of cross infection had been identified and reduced.

● Best practice guidance had not been followed by the home to identify any potential risks associated with the spread of infection. Risk assessments had not identified people who were more susceptible to the spread of infection and what risk this may pose to their health. This meant measures to reduce these risks had not been put in place.

● Assessments had not been completed to identify any environmental hazards that could cause and contribute to the spread of infections. We identified over the bed tables with no side trim exposing bare chipboard which could not be cleaned and would harbour bacteria.

● Annual water testing for legionella had been completed and no legionella was found in the sample provided however, ongoing maintenance and checks had not been completed to prevent the risk of legionella. We found a large build-up of limescale in basins, bathtubs, shower heads and in the laundry room. This increased the likelihood of legionella and had placed people at risk of harm.

● We found opened toiletries in communal areas including bathrooms and 2 people told us they had found open toiletries in their room when they moved in. This placed people at risk of cross infection.

● The flooring in communal toilets and bathrooms had a build-up of dirt in the corners. The flooring had begun to lift away from the wall which made effective cleaning difficult.

● Bins did not have lids and were not pedal operated. This did not follow best practice guidance to prevent the spread of infections.

Systems to keep people safe from the spread of infections had not been established or operated effectively. This had placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The registered manager told us they were proud of their infection and prevention which had meant the home had not experienced a COVID-19 outbreak until recently.

● People told us staff cleaned their rooms, one person said, "staff are always cleaning the even move the furniture and clean behind it.

● There were no restrictions to visits at the time of our inspection.

Staffing and recruitment

● People told us there were enough staff to meet their needs. People told us when they pressed the call bell, staff attended in a timely manner. One person told us, "They leave the call bell on my bed side table and always respond when I press it."

● Staff had been recruited safely into the home. Appropriate Disclosure and Barring Service (DBS) checks had been made. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the systems and processes to support the effectiveness of people's care, treatment was not always inconsistent meaning people did always get good outcomes.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection no person living at The Gables had an authorised DoLS in place.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The Gables did not ensure it obtained people's consent to care and treatment. We reviewed 9 care plans and did not find any records to demonstrate people's consent had been sought.
- The home had not ensured people's capacity to make decisions had been assessed when needed. The registered manager informed us 14 people lacked capacity to consent to living at The Gables and DoLS had been applied for. We reviewed 8 out of the 14 people's care records and found no mental capacity assessments had been completed to determine if the person could consent or not.
- Where restrictions for safety had been put in place that restricted the movements of people, including bed rails for 2 people and a lap belt for 1 person, consent had not been sought and mental capacity assessments had not been completed. This meant best interest decisions had not been completed to ensure the restriction was in the person's best interest and the least restrictive option to reduce risks they faced.
- Staff had not received up to date refresher MCA training. This had contributed to staff not identifying the MCA had not implemented in accordance with the framework as a result. The registered manager told us, "Training is out of date and is something we plan to do in the near future."

People had been placed at risk of significant infringement to their rights and welfare. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We discussed our findings with the registered manager after our first day of inspection. Mental Capacity Assessments had started to be completed by our second day of inspection however, these were not decision specific and stated, "all aspects of care" which did not follow the Mental Capacity Act 2005 framework.
● Staff told us how they asked for consent before they commenced care. Staff understood capacity could fluctuate and told us how they would support people to decide what they wanted to wear.

Staff support: induction, training, skills and experience
● The home understood staff needed training and development, but this was not always up to date or in line with best practice. This had placed people at risk of staff not identifying and meeting their care needs.
● There were people living at The Gables who required positive behaviour support, catheter care, diabetes, and pressure care management however, staff had not completed training to support them effectively with this.
● Since July 2022 all registered health and social care providers have been required to provide training for their staff in learning disability and autism. This training had not been provided to the staff at The Gables.
● We discussed our findings with the registered manager who told us, "The training is out of date as we had to cancel due to COVID-19."
● Staff did not always receive supervisions and did not always feel supported. Comments included, "I know I should have supervision, but I don't get it. It would be useful to have a time to highlight things" and, "Supported? Not very to be honest. The senior care assistants are fine, the staff really run things themselves, they are a good bunch and get by. Management knows the staff are good."

Staff had not been provided with the training necessary to meet the needs of the people living at the home and this had placed people at risk of not having their care needs met. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Adapting service, design, decoration to meet people's needs
● The design and decoration of The Gables did not always support people to orientate themselves to their surroundings. We observed people were not always able to locate their bedroom or the bathroom. We discussed this with the registered manager and area manager who told us they would develop plans to enhance the environment for people who were living with dementia.

We recommend the provider consults good practice guidance around providing a dementia friendly environment for people who use the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments had been completed before people moved into The Gables however, these had not always been used to form the basis of care plans. This meant care needs identified did not always have plans in place with instructions for staff to follow to ensure people's care needs were met.
● Care and treatment had not always reflected current evidence-based guidance, standards and best practice. The registered manager told us, "I am aware we have not brought the home up to date in the past 20 or so years and we have some work to do."

Supporting people to live healthier lives, access healthcare services and support, Staff working with other agencies to provide consistent, effective, timely care
● Systems and processes were inconsistent and did not support co-ordinated care. We received feedback from professionals that information was not always made available to them when they needed to make decisions about the care needed in an emergency.
● We reviewed 9 care plans and did not find records to demonstrate important information could be

provided to healthcare professionals visiting the home in an emergency.
● There was a lack of robust and effective systems for staff to report their concerns to senior staff for actions to be taken where necessary. For example, 1 person's skin was deteriorating however this was not reported to a district nurse.
● Visiting healthcare professionals spoke positively about The Gables. We received comments such as, "You will not find a home that cares more for the people living in the home", "the home is nice, personalised and the staff are willing to help, I would recommend the home" and, "If it was one of my family, I'd be banging on the door to get them in."

Supporting people to eat and drink enough to maintain a balanced diet
● The cook knew and understood people's nutritional needs well. Kitchen staff told us, "We have a 24-hour kitchen, if anyone wants anything outside of normal mealtimes, they are more than welcome."
● People were involved in decisions for upcoming menus and people told us they were given plenty of choice if they did not like what was on offer on the menu.
● People chose to sit in armchairs and receive their meals on trays. This did not always support a social experience and promote regular repositioning however, the people living at The Gables told us they enjoyed having their meals like this. Staff spoke with people, offered salt and pepper and ensured everybody had access to the drinks they preferred. Meals were well presented.
● People spoke positively about the food and drink they received at The Gables. People and their relatives told us, "The food here is excellent", "you can choose what food you want, and it is good quality" and, "[person] always tells us how good the food is, we are so pleased as they didn't eat much at home."

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 our last inspection we rated this key question Good. At this inspection the rating has changed 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.

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

- Systems for identifying, capturing and managing organisational risks and issues had not been effective and this had led to shortfalls being identified at this inspection.
- The registered manager's auditing systems and processes were not sufficient to all the areas of improvement we found throughout this inspection.
- The registered manager was responsible for everything that needed to be done at the home. This included all the audits, managing staffing and monitoring the care people received. Staff told us they were not aware who was responsible to do these tasks when the registered manager was not at the home to ensure people received quality care.
- A robust system and process was not in place to analyse accidents, incidents, safeguarding concerns and complaints for any themes and trends to be identified. This meant quality performance had not always been assessed, potential risks to people not always identified and lessons not always learned to drive improvements. This had led to widespread shortfalls and poor outcomes for some people using the service.

There was a lack of governance and oversight of The Gables, this had led to shortfalls and people had been harmed and were at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- We discussed our findings with the registered manger and area manager who told us a new governance system had just been introduced. The area manager said, "You are not telling me anything I wasn't aware of. We know we have some work to bring The Gables up to the standards we expect."
- The area manager provided us with an action plan immediately following our inspection detailing actions they were putting in place to ensure people were safe.

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

- We received positive comments from people, relatives, visiting professionals about the registered manager of the home however, systems and processes had not supported the home to be well-led. This had led to poor outcomes for some people living at The Gables, such as people being placed at risk from falls and poor skin integrity.
- We received mixed feedback from staff about the leadership and management. Comments included, "I am

confident in the leadership of [management team], I have a lot of faith in our care home" and, "Management are not leaders, they are friendly and very laid back. Staff do more of the day-to-day sorting."

● People and relatives told us they felt the registered manager cared about the people living at the home. We received comments including, "[registered manager] always says hello to me", "[registered manager] keeps us updated and looks after [person] well" and, "[registered manager] is very helpful."

● The Gables had not informed the local safeguarding team and CQC when people had been placed at risk of harm. This meant external scrutiny of the home was not possible to ensure people were safe from harm.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The registered manager told us feedback was sought from people, relatives and healthcare professionals to assess the quality of the service provided by The Gables. We were given people's feedback survey's to review however, did not receive any relative or healthcare professionals surveys to review.

● People had given positive feedback in the recent quality surveys. Comments included, "I enjoyed my temporary visit so much I decided I wanted to come back permanently to stay", "All I can say is it's a lovely home. The staff are all lovely" and, "The staff are good."

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 HSCA RA Regulations 2014 Staffing Staff had not been provided with the training necessary to meet the needs of the people living at the home and this had placed people at risk of not having their care needs met.

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 11 HSCA RA Regulations 2014 Need for consent The Gables did not ensure it obtained people's consent to care and treatment. The home had not ensured people's capacity to make decisions had been assessed when needed.

The enforcement action we took:

We issued a warning notice with a date the home was required to be compliant by.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People had not always been protected from avoidable harm. The risks to people's health, safety and welfare had not always been assessed.

The enforcement action we took:

We issued a warning notice with a date the home was required to be compliant by.

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 Robust safeguarding systems and processes had not been established to protect people from the risk of abuse. Incidents of harm and potential harm had been recorded by staff in people's daily notes however, senior staff had not always been made aware and when they had, action to investigate and safeguard the person had not been taken. People had been harmed or placed at risk of harm without external scrutiny of the home.

The enforcement action we took:

We issued a warning notice with a date the home was required to be compliant by.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of governance and oversight of The Gables, this had led to shortfalls and people had been harmed and were at risk of harm.

The enforcement action we took:

We issued a warning notice with a date the home was required to be compliant by.