Morleigh Limited

St.Theresa's Nursing Home

Inspection report

St Therese Close
Callington
Cornwall
PL17 7QF
Tel: 01579 383488

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place on 25, 27 and 28 April 2015 and was unannounced. At this visit we checked what action the provider had taken in relation to concerns raised at our last inspection in February 2015. At that time we found the provider had not fully implemented an effective system to regularly assess and monitor the quality of service across the organisation. At this inspection we found a new Head of Operations had been put in post to address this and put new standardised systems in place to develop the organisations individual nursing and residential homes including St Theresa's. In February 2015 we found staff were not supported by a robust system of training, supervision and appraisal. At this inspection we found training had been brought up to date and staff had received appraisals although not supervisions.

St Theresa's Nursing Home is a care home that provides nursing care for up to 45 older people. On the day of the inspection there were 27 people living at the service. Some of the people at the time of our visit were living with dementia.

The service is required to have a registered manager and at the time of our inspection a registered manager was not in post. There had been a manager in post until a few

Summary of findings

days before the inspection when they had left suddenly without giving notice due to personal reasons. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider told us a new manager had been recruited and was due to start in post on 11 May 2015, when they would submit an application to become the registered manager of the service.

Risk assessments were in place and identified when people were at risk of falls. However there was no guidance for staff to help them minimise identified risks. We could not locate any evidence that falls were consistently recorded and action taken to protect people from the risk of falls.

Maintenance logs and audits were kept to identify any problems with equipment or the premises. However it was not evident that these were acted upon in a timely manner. Parts of the building were in need of decoration. The service was free from odour and clean throughout.

There were enough care staff on duty to help ensure people's health needs were met. There was only one nurse on duty at any one time. They were often rushed with several demands on their time. A care worker said; "the nurses are rushed off their feet." Someone using the service said; "If anything happens….one nurse, what does she do?"

Systems for administering and recording medicines were not robust. Medicines Administration Records (MAR) contained handwritten entries and deletions making some entries difficult to decipher. There were gaps in the records meaning it was unclear if people had received their medicines as prescribed.

No documentation could be located to evidence that applications had been made to deprive people of their liberty when necessary to keep them safe. We saw when one person left the building a member of care staff went with them. The correct legal procedures had not been adhered to.

Food and fluid charts were kept when people had been identified as being at risk from poor diet and/or dehydration. However amounts were not tallied at the end of each day meaning any low intakes might not be noticed. New forms were put into circulation to address this on the day of the inspection.

People told us they enjoyed the food and were given a choice. People's preferences and cultural needs were taken into account. People were supported to eat when necessary. This was done with dignity and kindness.

There was an activity co-ordinator in post who worked two hours a day during the week. People had access to a range of activities such as books, jigsaws and games. There was an activity timetable on the noticeboard but activities scheduled did not take place during the inspection.

During the inspection staff and senior management often found it difficult or were unable to locate information. It is important robust systems are in place to ensure people's care documentation and other related records are easily accessible in all circumstances.

We identified several breaches of the regulations. You can see what action we have told the provider to take at the back of 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 safe. Risk assessments did not clearly guide staff on how to minimise risk.

Where people were at risk of falls clear actions had not been taken to mitigate against this.

Systems for the recording and administration of medicines were not robust.

Is the service effective?

Requires Improvement

The service was not effective. There were no legal authorisations in place to allow the service to deprive people of their liberty. This meant the legal requirements laid out by the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were not being adhered to.

Parts of the building were in need of redecorating.

Staff had received appropriate training to support them to carry out their roles effectively.

Is the service caring?

Requires Improvement

The service was not entirely caring. People's preferences regarding night time routines were not always respected.

Staff were kind and sympathetic in their approach to people when supporting them.

People were able to make day to day choices about where and how they spent their time.

Is the service responsive?

Requires Improvement

The service was not responsive. Care plans were in need of updating. It was unclear how this was going to be organised.

Activities were available but these were not always in line with people's preferences.

There was complaints policy in place and the provider adhered to the timelines laid out within it.

Is the service well-led?

Requires Improvement

The service was not well-led. There was a lack of clear leadership within the service.

There were no clear systems in place to ensure records were up to date and available for reference at all times.

St.Theresa's Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place over three days on 25, 27 & 28 April and was unannounced. The inspection team consisted of two inspectors.

We reviewed information we held about the home before the inspection including previous reports and notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with six people who were able to express their views and two relatives. Not everyone was able to verbally communicate with us due to their health care needs. We looked around the premises and observed care practices. We used the Short Observational Framework Inspection (SOFI) over the lunch time period on the second day of the inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with three care staff, three nurses, the cook, the business support manager, the Head of Operations and the provider. We looked at three records relating to the care of individuals, four staff recruitment files, staff duty rosters, staff training records and records relating to the running of the home.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they believed they were safe, living at and visiting, the service. Staff had received training in safeguarding adults and had a good understanding of what may constitute abuse and how to report it. They were confident any concerns would be acted on. One told us; "I wouldn't work here otherwise."

People's care plans included risk assessments in respect of various areas, for example falls, skin integrity and manual handling. Those pertaining to falls and skin integrity calculated the level of risk for each person. However there was no accompanying information to guide staff on how to minimise the risk. For example we saw on person had been identified as being at high risk of falls. There was no information regarding whether this risk was higher at certain times of the day or in particular areas of the building. According to daily records this person had fallen on the 11 March. We could find no record of this in the accident book. However we did see records showing the person had fallen on several other occasions during February and March. No-one was able to locate the incident logs or any audit to establish if any preventative actions had been taken following the fall.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received concerning information that the boiler at St.Theresa's was not working effectively and was leaking carbon monoxide. On the first day of our visit we checked and found one of the two boilers was working. The building was warm and hot water was available. The boiler had been out of action for a short period but repairs had been carried out to address the fault. New boilers were being installed on the third day of the inspection. A carbon monoxide monitor had been installed in the boiler room to help ensure any leaks were quickly identified. Staff told us they were aware the monitor was in place. However no-one had been assigned responsibility for checking the monitor. Staff did not know if a leak would result in the monitor sounding an alarm or a flashing light. There was no system in place for checking the alarm or information for staff as to how it operated and what action to take in the event it should go off.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Maintenance logs for the building and wheelchairs were kept in the corridor to allow staff to record any faults or problems in a timely fashion. The logs did not record when action had been taken to address the problems. The provider told us the manager was required to send a printout report on a weekly basis to the organisations maintenance team who would then prioritise the work. A report had not been completed for the previous week when problems with four fire doors had been identified. The wheelchair log showed one wheelchair had been reported as having faults for the last three months. There was no evidence to show whether or not this was a reoccurring problem or had never been addressed. While looking round the building we saw one bedroom was being used to store a large number of air mattresses which were awaiting repair. A member of staff told us there had been a delay in getting parts to repair the mattresses although they had been ordered some time ago.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC had received concerning information in respect of staffing levels at the home, in particular nursing staff. There were two day nurses and one night nurse employed at the service. One of the day nurses split their time working in St. Theresa's and another of the Morleigh nursing homes. In addition there was a regular bank staff nurse who worked every other weekend and an agency nurse who was also used regularly. The manager had also worked some nursing shifts but they had left their position suddenly the week before the inspection. A nurse told us they often felt pressurised and relied on the assistance of the district nurse team. We observed a nurse preparing to do the medicines round and saw they were interrupted on four occasions with requests for help with dressings, to look at a pressure ulcer and speak with residents. On the final day of the inspection we were told the nurse dividing their time between two homes would be working solely at the service in future. They said this would mean they would be better able to organise their time in order to complete tasks such as updating care plans and undertaking medicines audits.

The service had been without administration support for a few weeks before the inspection. A new administration assistant had recently been employed and was just starting work on the second day of the inspection.

We looked at rotas for care staff for the week of the inspection and the previous week. Minimum staffing levels

Requires Improvement

Is the service safe?

were adhered to during this period of time. Staff told us for most of the time there were sufficient numbers of staff on duty to meet people's needs. However they felt it would be beneficial to have an extra care worker on shift during the morning to assist with getting people up and ready for breakfast. We saw people were attended to and call bells were answered promptly.

Medicines were stored in locked medicines trolleys in the nurse's office which was locked when unmanned. Medicines Administration Records (MARs) were kept to record when people had received their medicine. The records could be difficult to decipher. For example in one person's records we saw they had been prescribed a Butrans patch, which is used for pain relief, to be applied once a week. It had been marked on the MAR sheet that this was to occur on 21 and 28 April and 5 and 12 May. This had been scribbled out and re-entered for the 26 April and 3, 10 and 17 May. The alterations had not been signed to allow us to ascertain who had made the change or why. It appeared from the records the patch had been applied on the 26 April, however due to the overwriting of entries this was difficult to decipher. We checked the accompanying chart used to record when the patch was checked in order to attempt to clarify that the patch had been applied. This had not been completed since 4 April 2015.

There was no record on the MAR sheet of when the medicines had been received into the home and what amount. It had not been recorded on the MAR what amount of the medicine had been carried over when the new MAR was started. Another person's records stated they were to be given a prescribed medicine, (Clonazepam, used to control seizures), in the morning and at teatime. However we saw the MAR indicated on two occasions it had been administered at noon instead of tea time. Handwritten entries and alterations had not been countersigned to indicate the entries had been double checked to protect people from the risks associated with not receiving medicines as prescribed. We saw there were gaps in people's MARs where it had not been recorded whether or not the person had received their medicine as prescribed. We checked the amounts of medicines in stock for some people and found the numbers were in line with people having received their medicines correctly. This indicated the medicines had been given but not signed for.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

At our inspection in February 2015 we identified staff were not supported by a system of training, supervision and appraisal and we found the provider was in breach of the regulations. At this inspection we saw staff had received training in areas defined by the provider as necessary for the service. We saw certificates in staff files to verify that training in areas such as infection control, fire safety and food hygiene had recently been completed. In addition some staff had received training in areas specific to people's health care needs such as dementia awareness and person centred thinking. Nurse staff told us they had not received up to date training in certain areas which they felt would improve their ability to carry out their role effectively. We discussed this with the business support manager who assured us arrangements would be made to address these gaps in the nurses training. Staff had received an appraisal in the two months preceding the inspection. However supervisions were still not taking place.

The provider told us they believed the previous manager had made applications to authorise the service to deprive people of their liberty in order to keep them safe as required by the legislation laid out in the MCA and DoLS. However they were unable to find any evidence to confirm this, either in individual files or elsewhere. During the second and third day of the inspection we saw one person who we were told did not have capacity due to their dementia on several occasions go to the front door and to windows, attempting to open them. On the third day this person managed to open the front door and leave the building. This highlighted the premises were not adequately secured to prevent people from leaving who might have been at risk if they left unobserved. The risk had not been properly assessed or any action taken to minimise it. Care staff immediately followed the person and one stayed with them and accompanied them on a walk around the building. This demonstrated to us that the person was unable to leave the building without supervision and therefore there should have been a DoLS in place to authorise this. The Head of Operations told us they would address this immediately. They would also consider which other residents would require applications to be made and follow this up accordingly.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where it had been identified that people were at risk due to poor diet or fluid intake food and fluid charts were completed on a daily basis. However the charts did not indicate how much fluid people should be taking and the amounts were not totalled at the end of the day. Information about food intake was limited and only indicated what proportion of a meal a person had eaten, i.e. half or a quarter. A file containing completed charts only had a few charts in it. No-one was able to locate the remaining charts although we were told, "They are probably in the office somewhere." The head of operations showed us a new chart which had been introduced across the organisation. This included sections for recording what people's food and fluid intake should be and a box to record the daily total. They expressed surprise that it was not being used at St. Theresa's and immediately arranged for copies to be printed off and put into use.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We used SOFI to observe the care and support people received over the lunch time period on the second day of the inspection. People who needed assistance were supported with dignity and staff ensured they were at eye level with people while supporting them. This meant they were able to engage with them and support them effectively. We heard one person tell the care worker they did not like the meal and would not be able to eat it. The care worker reassured them and offered to get them a salad which the person agreed to. Another care worker commented; "I don't think you'll be able to get one now. You need to order in advance." The care worker went to the hatch and spoke with someone in the kitchen, they then returned with the original meal. They encouraged the person to eat a little more but the person reiterated that they did not like it. We spoke with the care worker later who confirmed they had not been able to get a salad to offer the person. On the following day we discussed this with the cook who had been off duty at the time. They told us this was an exception and would not have happened if they had been working. They assured us they would find out exactly what had happened and take steps to make sure it did not happen again.

Requires Improvement

Is the service effective?

People were supported to access external health care professionals to meet their specific needs. For example district nurses, opticians, GP's and dentists. We heard a nurse talking with someone about arrangements to see their GP.

On the second day of the inspection we looked around the building. We found the service to be clean although some areas were in need of decoration. For example an assisted bathroom on one of the wings, (red wing) was shabby and the bath panel did not meet the floor all round leaving gaps between the bath sides and the floor. In some areas carpets had become thin and worn and there were areas of the building which were in need of repainting. There had been a leak in the foyer resulting in the artex on the ceiling becoming blackened and sagging. We discussed this with the business support manager and provider who acknowledged the building was "tired" in some areas. On the third day of the inspection the business support manager was preparing to do a full audit of the building to ascertain what needed doing and which areas should be prioritised.

One toilet close to the dining area was locked and marked out of order. This was being used to store activity equipment. We brought this to the attention of the business support manager who arranged for the equipment to be moved and the toilet made available again.

The building offered several areas for people to sit including a quiet area looking out over the garden. There was a range of books available and comfortable seating. The garden was accessible and contained raised beds so people were able to be involved in planting if they wished. Bedrooms looked out onto small garden areas. However there was no gardener with responsibility for maintaining these areas and if people or their relatives were not able to tend to them they had become overgrown and did not enhance people's environment.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

People told us they were happy living at St Theresa's and staff were pleasant. One person told us; "It's the best place there is." People were treated with kindness and compassion. Staff spoke with people gently and enquired about their well-being and physical comfort regularly. We heard one person was distressed and anxious, staff were quick to respond to their requests for assistance and spoke kindly ensuring the person was settled before they moved on. Another person was concerned about their medicine and we heard a nurse talking to them and letting them know they would be speaking with the doctor. The person was happy and reassured by the response.

People were able to choose where they spent their time. One person preferred to stay in their room for most of the day which looked out onto a small section of garden. Their relative had requested they be moved to a room overlooking the street so they could "watch the world go by." Arrangements were being made for this to happen on the last day of our inspection. The person's relative told us how they planned to bring soft furnishings and personal photographs in order to make the room more homely, comfortable and appropriate for the person's tastes and interests.

People's privacy was respected. Staff knocked on doors before entering people's bedrooms. Doors were kept closed when people were being supported with personal care.

People told us residents meetings were held but infrequently. During the inspection we observed people were asked often about day to day choices, for example where people wanted to eat, if they were happy where they were or wanted assistance to move to another area and if they wanted help to start an activity.

A relative told us about a recent incident when their family member had been watching television in their room in the evening at 8:15. They said a care worker had come into their room and switched the TV off taking the remote control from their hand. They had then left the room closing the door behind them. The relative had spoken with the care worker about the incident who had not denied the incident had occurred but had said; "It wasn't 8:15 it was 11:15." This did not show respect for the person's wishes. We discussed this with the provider and head of operations who assured us there was no "lights out" policy and told us they would speak with the care worker concerned.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visitors told us they were always made welcome and were able to visit at any time. People could choose where they met with their visitors, either in their room or different communal areas. We saw visitors were able to bring in pet dogs.

Requires Improvement

Is the service responsive?

Our findings

Before moving into the service people had their needs assessed to help ensure the service was able to meet them. Information in respect of how people were to receive their care and treatment was recorded in people's individual care plans. Care plans were divided into sections which contained information in respect of peoples care needs for that particular area. For example communication, moving and handling and nutrition. The quality of care plans was inconsistent and information was sometimes difficult to locate. Plans were in place to update the information and a new template had been identified which laid the information out in a clearer format. Nurse staff told us they would be responsible for this but were unsure how long it would take as they had not been given any dedicated extra time to complete the task and they were already pushed.

Some people's care records contained life histories. These are important as they help staff gain an understanding of who people are and enable them to have more meaningful communication with people. The life histories varied in the depth of information contained. We discussed this with the provider who acknowledged the value of the information. They told us it could be difficult to obtain details from people but it was an on-going process. They arranged for a student care worker to spend time with one person talking about their past life and recording the information for inclusion in their care plan.

Care files contained daily records and 24 hour nurse records. These were not completed consistently. For example we reviewed one person's records, who was at risk of falls, from 9 March until April. Nothing was recorded for 17 – 21st March, 23, and 24 March. This meant it would be difficult to ascertain any common circumstances when the person did or didn't fall and so mitigate any risks.

There was an activity co-ordinator employed for two hours a day during the week. They were responsible for organising activities for people within the home including visits from outside entertainers. They told us it could be difficult to engage with everyone during this time frame as it was difficult to find group activities that interested everyone with one to one activities being often more appropriate but time consuming. During the inspection we saw people who were more independent were provided with materials to keep themselves occupied such as paints and brushes. We saw the activity co-ordinator spent time with a few people but some were left with little to occupy them throughout the day. The activity co-ordinator had not had any specific training or advice about how to make activities meaningful and relevant for people who may be living with dementia.

One person told us they had been asked what sort of activities they would like available and had expressed an interest in visits from local historians or people with local knowledge. However this had not been arranged. They told us a musician sometimes came in and added; "The man sings the same songs in the same order, it doesn't interest me."

A timetable for activities was on display on the notice board in the main entrance to the home. This stated that on the 27th of April there would be a painting session and on the 28th 'John and Jill music'. We did not see either of these activities take place.

Around the service there was a wide range of books, jigsaws and games such as giant scrabble available. However we did not see anyone making use of these facilities.

There was no vehicle available for people to have trips out of the home although people told us they had one in the past. We discussed this with the provider who told us when they had suggested trips out to people they had not expressed an interest. Staff told us it was difficult to take people out individually as this meant taking staff away from the service.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had recently received a complaint which they had responded to appropriately and within the time frame laid down in the organisations policy. Details of the complaints procedure were displayed in the main entrance to the home.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in February 2015 we found there were no systems in place to assess the quality of the service provided to people across the organisation. This meant the quality of care and treatment might be inconsistent and there was a lack of opportunities to share good working practices. We found the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

At this inspection we checked if the provider had made the necessary improvements to comply with this regulation. The organisation had recently employed a Head of Operations in order to streamline the service provided by the Morleigh group across all of its services in order to offer a more consistent and reliable standard of care. Staff told us they saw this as a positive move. We met with the Head of Operations and discussed the plans they had in place to develop the service. They told us the organisation was getting "more co-ordinated as a group." A monthly managers meeting had been initiated to give an opportunity for managers to share good working practices and discuss any issues. Managers were being required to submit monthly reports to enable the Head of Operations to track any developments. In addition they were planning to visit each service monthly to carry out audits in line with the five CQC inspection questions. Following the visits action plans would be issued to address identified areas for improvement. All policies and procedures were being reviewed and standardized across the organisation.

The Head of Operations was looking to develop the skills of staff at all levels. A new induction pack had been developed for new starters which incorporated the new Care Certificate. All managers were being asked to review existing staff skills and identify any training needs. They told us part of their role was to; "upskill" managers.

However the Head of Operations had been required to act as manager at one of the group's nursing homes due to a manager leaving the post. This meant they were not able to dedicate their time to ensuring the quality of the service provided at an organisational level was robust.

The manager had left the service the week preceding the inspection without giving notice. They had only been in the post for eight weeks. The previous manager had not been registered and had been moved to one of the organisations other homes after a few months. There had not been a registered manager in post at St Theresa's for 12 months. People, relatives and staff told us they found this unsettling. A relative commented; "The manager was just beginning to get the place comfortable. I don't know how many managers we've had here." Another said; "I think they keep me informed but they keep changing managers and I don't know who it is now." The provider told us a new manager had already been appointed and would be starting work in early May when they would submit an application to the Care Quality Commission to apply to become registered manager. At the time of the inspection out of seven nursing and residential homes only two had a registered manager in post. Three of the five services without a registered manager had been without a registered manager for over 12 months. This meant there was a risk there would be a lack of consistency and clear leadership throughout the services. One member of staff told us; "The communication is so disjointed."

Staff told us they enjoyed working at the service but had little support from higher management. They told us they assumed any communication was between the manager and the provider as necessary. Staff told us; "They come in and go and sit in the office and then go again." And "I'm not sure they realise how much we do." Staff meetings were not held regularly although one had been held the month prior to the inspection for staff on duty. The minutes did not record how many this was. We saw a nurses meeting had been arranged for September 2014, however we were unable to establish if this had taken place and no records could be located.

There was a lack of consistency in the recording systems within the service as outlined in the report. We were told audits took place regarding falls and other incidents and accidents but we were unable to locate any records to verify this. Staff were unable to find any DoLS applications and we were told the training matrix had been deleted. There was no-one in place with an overview or thorough knowledge of the service and the systems and processes in place. Although this was partly due to the sudden departure of the manager it is important that systems are able to operate effectively in all circumstances.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Care and treatment of people who used the service did not meet their needs and reflect their preferences. Regulation 9(1)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: Premises and equipment were not properly maintained. Regulation 15

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not being provided in a safe way for people who used the service. The provider was not doing all that was reasonably practicable to mitigate identified risks. Medicines were not managed properly and safely. Regulation 12(1)(2)(b)(g)

The enforcement action we took:
We have served a warning notice to be met by 15 June 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established and operated effectively to enable the registered person to assess, monitor and mitigate the risks relating to the health safety and welfare of service users and others. Accurate records in respect of people who used the service were not maintained including records of the care and treatment provided. Regulation 17 (1)(2)(b)(c)

The enforcement action we took:
We have served a warning notice to be met by 15 June 2015