Huntercombe (No 13) Limited

Wheaton Aston Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 30 June 2016 and was unannounced. This is the service's first inspection since the since registration with the new provider registered with us in March 2016.

Wheaton Aston Care Home provides nursing and personal care and support for up to 36 people. At the time of this inspection 27 people used the service.

The service had a registered manager. 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.

Staff were aware of the action they should take where they had concerns regarding the safety of people. However, some unexplained and unwitnessed incidents had not been identified as potential abuse and they were not reported or investigated.

There was insufficient suitable staff available to meet people's individual needs. People experienced delays when staff were needed to provide them with the care and support they required.

The provider did not consistently follow the principles of the MCA 2005 to ensure that people consented to or were supported to consent to their care, treatment and support.

Systems the provider had in place to monitor and improve the quality of the service were ineffective. Audits had not identified the shortfalls in the care being delivered.

The provider was not fulfilling their legal obligations of their registration and did not notify us of serious incidents and events.

Risks to people's health and wellbeing were identified and reviewed, but care plans lacked the detail of the action needed to mitigate the risks to people.

Some people did not receive their medicines in the way they were prescribed. Not all topical medicine monitoring documents were completed accurately and at the time of the administration.

People generally told us they enjoyed the food and were provided with suitable amounts of food and drink of their choice. Not all records for the purpose of monitoring people's dietary needs had been fully completed to ensure people's nutritional needs were fully met.

People were supported to observe their faith and take part in activities, which met their cultural needs and interests, however community based activities were not arranged by the service.

Staff received the training they needed to provide care and support to people. Improvements to the way training was arranged had been identified.

People had access to health support and referrals were made to relevant health care professionals where there were concerns about people's health.

Staff were recruited in accordance with the provider's recruitment procedures.

We saw staff showed care and kindness towards people who used the service. People told us staff were caring that they had confidence in them to provide the support they needed. People's rights to privacy and dignity were upheld.

There was a complaints procedure and people knew how to use it. People and relatives we spoke with told us the registered manager and staff were kind and approachable.

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 consistently safe. People were not safeguarded from abuse as concerns were not raised with the local authority. People experienced delays in receiving the support they required because there were insufficient numbers staff available to meet their needs in a timely way. Risks to people's health and wellbeing were identified and reviewed but not always managed in a safe or consistent way. People did not always receive their medicines as they were prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective. The provider was not following the principles of the MCA to ensure decisions were made in people's best interests. People told us they had sufficient to eat and drink but some people experienced substantial delays between meals due to staff availability. Records were not consistently completed to ensure people who were nutritionally at risk had sufficient each day. Staff received training, but further training was needed to ensure people received safe and effective care. People had access to a range of health care professionals and if they became unwell.

Is the service caring?

Requires Improvement

The service was not consistently caring. People told us they were supported by staff that were kind and caring in their approach but some people had to wait considerable periods of time for support from staff. People were treated with dignity and respect. People were encouraged and involved in decisions made about their care and treatment

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Care plans were not always reflective of people's current care and support needs, which meant staff would not always have the information to support people with their needs. Leisure and recreational activities were arranged but there were limited opportunities for community involvement. The provider had a complaints procedure in place and people knew how to complain.

Is the service well-led?

Inadequate

The service was not well led. Systems the provider had in place to monitor and improve the quality of the service were ineffective. We were not notified of significant events that affected the health and well-being of people who used the service. People were receiving care that was unsafe and the provider was in breach of several Regulations of The Health and Social Care Act 2008.

Wheaton Aston Care 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 30 June 2016 and was unannounced.

The inspection team consisted of two inspectors.

Prior to the inspection we looked at the information we held about the service. The provider completed a Provider Information Return (PIR). This is a form that asked the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the notifications that we had received from the provider about events that had happened at the service. A notification is information about important events which the provider is required to send us by law. We reviewed the information we received from other agencies that had an interest in the service, such as the local authority and commissioners.

We spoke with 10 people who used the service; they were able to tell us their experiences with the service. We spoke with other people but due to their communication needs they were unable to provide us with detailed information about their care. We spoke with a relative of people who used the service to gain feedback about the quality of care. We spoke with the deputy manager, three regional support managers, a registered nurse, two care staff, a member of the ancillary team and two visiting health care professionals. We looked at nine people's care records, two staff recruitment files and the quality monitoring audits. We did this to gain people's views about the care and to check that standards of care were being met.

Requires Improvement

Is the service safe?

Our findings

Staff told us they knew how to identify and report abuse, and if they suspected someone was being abused they would report it straight away to either the managers or the nurse in charge. However, we found that incidents of suspected abuse or neglect were not always reported to the local authority as required.

We saw one person had sustained a substantial injury to their arm; this person was unable to tell anyone how this had occurred. We saw that action had been taken to treat the wound and dressings were applied to ensure the wound did not become infected. We did not see that any investigation had been completed to explain how the injury occurred, but the deputy manager told us of the action they had taken to ensure the risk of further injuries were minimised. This incident had not been reported to safeguarding team or to us. We contacted the safeguarding team at the local authority after this inspection and referred the concerns we had in regard to this unexplained injury.

Some people had poor mobility and had a history of falling. We saw some people who had been assessed as being at risk of falls, had suffered unwitnessed falls. This person was unable to mobilise independently and required two staff to support them with moving. It was recorded the person was mainly nursed in bed. Action had been taken to reduce the risk of recurrence but these significant events had not been reported to safeguarding team or to us. There was a risk of continued harm because no appropriate investigations had taken place

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People without exception told us the service was short staffed. Staff told us and we saw people experienced delays in receiving support. One person who used the service told us: "It's terrible for the girls. They have too much to do. At times they struggle with staff. They're rushed off their feet, when there are only four of them it's too much. I've waited almost an hour today (for the toilet) because I needed the sling". Another person said: "One Saturday morning there was six carers on, there's usually five, and it was lovely. We didn't have to wait. Sometimes we can't get up until 11.45 because they are so busy. The nurse is always pushed and very busy". Another person commented: "The staff are lovely, but they look worn out because they're so busy. There are no staff and you're left waiting and waiting and waiting. I wait for too long for the commode and to go to the toilet". A relative commented: "At times they struggle with staff". Staff also commented on the staffing situation and said: "It's very stressful there are not enough staff, we do not have enough time and yes there are times when people have to wait for support".

Staff told us breakfast was served at 8.30 and 12 people required staff support. One care staff was allocated to serve the meal to all 27 people, of whom 12 people needed additional support. They said: "Quite a few need help to eat and it takes a long time to do this". Staff confirmed that two people still required support with their breakfast at 11.20. This meant two people waited up to three hours before they were supported with their breakfast. We saw one person had an 11 hour period between meals from supper to breakfast. The person was unable to make their needs known and relied on staff to support them with day to day

living. A food and fluid chart was in place to monitor their daily intake and recorded the times of when nutritional support was provided. There were insufficient staff to meet the care and support needs of all people in a timely way.

Staff told us and we saw that some people's care need required additional monitoring, we saw charts and documents were provided to record this level of support. we saw that not all documents had been fully completed to give a full account of the support provided. Staff were aware of the need to complete these documents but said there were times when they were rushed and they forgot to complete them .

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

Some people were at risk of developing sore skin and needed regular support with repositioning and specialist equipment to support them. For example, air flow mattresses were needed to support people with reducing the risk of them developing sore skin. Some support plans and monitoring documents did not record the information of the most appropriate setting of the mattress to offer the most effective support. Staff told us they turned the mattress setting on to the highest level when the person was out of bed and turned the setting down again when the person returned to bed. They were unsure of why they did this but commented 'it's what we do'. NICE guidelines informs that air flow mattress pressure should be set for each individual person according to the manufacturer's guidelines and take account of the person's weight. The settings used and the individual's weight should be recorded in their record. The provider was not following the guidance which meant for some people the equipment in use would not be as effective as it should be.

Staff told us they regularly supported people with repositioning throughout the day to prevent them developing sore skin when they were unable to do this independently. The frequency of the repositioning varied according to the individual needs of each person. Staff were aware of the different timings and were vigilant to ensure people were supported at the required times. We saw records were completed when staff supported people with this.

We looked to see how people's medicines were managed and saw they were stored safely and administered by trained staff. Some people had been prescribed medicines that could be taken when needed and as required. These medicines were often referred to as PRN medicines. We saw information had been provided to inform staff of when and how often the medicines could be offered. We saw one person had been prescribed PRN medicines to help when they were feeling anxious and distressed. The nurse told us and we saw this person received their PRN medicine on a very regular basis each day. The nurse offered a reasonable explanation but nevertheless this person did not receive their medicine as it had been prescribed and had not contacted the person's doctor for a review of their medicines.

Some people had been prescribed external creams and ointments to help manage their risk of skin damage. Some but not all of the topical medications administration records (TMAR) included the type of cream to be applied, to which part of the body and the frequency. We did not see this information was recorded in a person's care plan. There were many gaps on the TMAR chart so we could not determine if staff followed the administration instructions and people received their treatments. Staff told us they did apply the creams but admitted there were times when the records were not completed. This meant there was no assurance that people received the treatment they had been prescribed.

We looked at the way in which staff had been recruited to check that robust systems were in place for the recruitment of staff. We saw the provider had safe recruitment procedures in place; checks to ensure that people were suitable and fit to work had been carried out prior to them being offered a position. Staff

confirmed that checks had taken place prior to starting work at the service. These procedures ensured staff were suitable to work with people who used the service.

Requires Improvement

Is the service effective?

Our findings

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 Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The Deprivation of Liberty Safeguards (DoLS) is part of the MCA. This legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom.

The deputy manager told us that currently no person residing at the service was being deprived of their liberty. One person who used the service told us: "There are set times for everything, meals and drinks, get up time, bed time, wash time". We saw some people who were subject to continuous monitoring and supervision and who would be unable to consent to this. We saw other people who used specialised chairs from which they would be unable to get out of independently. The provider had not referred people to the DoLS team and had not recognised that people may be being unlawfully restricted of their liberty.

This was a breach of Regulation 13 of The Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

We saw some people had been assessed as having fluctuating capacity and as such would need support with making important and specific instructions. We saw one person had a decision made on their behalf about their end of life care by a doctor and a nurse. There was no capacity assessment to determine the decision making abilities of the person, their involvement in the discussion or that of their representative. We saw people had been assessed as having 'fluctuating capacity', there was no indication they had been involved in making decisions about their care and welfare, we saw decisions had been made on their behalf. The MCA had not been followed to ensure that this decision was in the person's best interests.

We saw another person had a nominated Lasting Power of Attorney (LPA). An LPA has the legal authority to make decisions on a person's behalf if they lack mental capacity at some time in the future or no longer wish to make decisions for themselves. The LPA had authorisations to make decisions in regard to the person's finances but we saw they had been involved with decision making regarding the person's care and welfare. The managers were unable to tell us if this person had the authorisation to make the care and welfare decisions on the person's behalf.

This was a breach of Regulation 11 of The Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Most people told us they enjoyed the food and they had sufficient to eat. One person we spoke with told us: "I had a good breakfast today. Very nice. Food is usually very nice and you get a choice". Another person said: "The food is not home cooking but as near as it could be. They do their best. It's not always as hot as it could be. I like spicy food and get it. There's a choice of two meals and I can ask for other things. Their jacket

potatoes are lovely". However another person said the sandwiches at tea time were always the same and not as appetising as they once were. There was a good selection of menu, and people were offered alternatives when they preferred something different. Most people had breakfast in their rooms and at lunch time we saw more people used the dining room. We saw that some people had to wait considerable periods of time for support with their meals due to the availability of staff and high numbers of people who required support.

People considered to be nutritionally at risk were provided with fortified diets and food supplements to support them with adequate daily nutrition. Some people had fluid and diet charts to monitor their daily intake. We saw some of the charts had been insufficiently completed so we could not be assured that people received sufficient daily nutrition and fluids to fully meet their needs. Staff were aware of the need to complete the food and fluid charts but told us there were times when they were rushed and they forgot to complete them.

The managers told us the training for staff had been revised and instead of providing staff with computer based learning arrangements had been made for staff to receive face to face training in small groups. The deputy manager told us they recently had training in train the trainer so could roll out training sessions at the service. Topics included moving and handling and pressure ulcer management. Staff told us the concerns they had with e learning and welcomed the change to face to face training, they said; "This will be so much better, computer based learning can be so much of a bug bear and it takes up so much time". Care staff confirmed they had received training in pressure ulcer management. One person who used the service told us they had a very sore area and the care staff 'turned' them often which they said 'helped'. We saw care staff supported people well with repositioning when people were at risk of developing sore skin and pressure ulcers. However some staff needed more training and guidance documented in people's care and support plans for the use of pressure relieving equipment.

Each care staff had been, or will be, provided with a learning booklet where they could record the training they had received, information on the one to one supervision sessions and the annual appraisals. The managers told us that training in the Care Certificate was on-going and being provided for all staff.

Staff supported people to access health care services when they became unwell or required specialist interventions. People had access to regular consultations with their doctor if this was requested and required. Referrals for advice and support were made and guidance from health professionals was being followed. A visiting GP told us: "The nurses are very responsive. They always call the surgery if there are any issues or concerns. Staff know people well and they here get good care here". A visiting community health worker told us they had concerns that a person who used the service was experiencing pain and they [the visiting community health worker] was unsure whether the person had received pain relief medication. We spoke with the nurse on duty who confirmed the person had received their prescribed pain relief but the person's doctor would be contacted, and asked for a visit to review the person's medication. The doctor arrived during the afternoon and reviewed the person's pain medication.

Requires Improvement

Is the service caring?

Our findings

A relative of a person who used the service told us: "It's all good really. When mum fell we came to see what it was like and were impressed from the start. Everyone's really friendly and makes time for you". A person who used the service said: "It's pretty good. I've been very lucky; I can choose what I do. The carers are pretty good. I'm very happy to be here. I can see the trees and I like that". People who remained in bed were visited at regular intervals by staff who attended to their comfort and well-being. One person told us: "I stay in bed now, the carers are very good and make sure I am comfortable and have everything that I need". We saw some positive and kind actions between staff and people who used the service. However low staffing levels impacted on people's welfare, we saw people had to wait for assistance to the toilet and for support with their nutritional needs.

Staff were aware of people's individual care needs and explained the support they offered to different people. They told us about the changes made to the repositioning routines for a number of people when their needs had changed and they required more or less frequent interventions. We saw one staff member gently encouraging and supporting a frail poorly person to have a drink and a bite to eat. Staff explained what the food and drink was and stayed with the person until they indicated they had had sufficient. Staff made sure the person was comfortable before leaving.

We saw each person had a care plan that was based on an assessment of their care and support needs; where possible the person had signed the records and documents to indicate their inclusion and agreement. We saw it recorded where a person was unable to sign but the plan had been discussed with them. Some people's representatives were included in the process on behalf of their relative. To obtain a holistic view of the person we saw that life histories had been recorded, this offered information about the person's past life and significant life events.

We observed people's privacy and dignity was upheld. Staff were vigilant in ensuring people's privacy was upheld when personal care interventions were required. Consultations with doctors and district nurses were conducted in the privacy of the person's bedroom.

Requires Improvement

Is the service responsive?

Our findings

All people who used the service had an individual plan of care based on an assessment of their needs. The plans gave an overview of people's care and support needs. We saw some conflicting information recorded in various documents that related to the same support need. For example one document would record the person was at high risk of falls but the level of need was assessed as medium. We saw a person's moving and handling plan had been reviewed which recorded they could 'sit out during the day'. It was recorded in another document that the person was 'mainly nursed in bed'. We saw in another document that a person had a catheter to help with continence; staff told us this person did not now have a catheter. Staff we spoke with had a good knowledge of people's individual care and support needs but the care and support plans did not accurately correspond. This meant that people were at risk of receiving inconsistent or unreliable care.

One person complained of severe pain which had not eased following their pain relief medication. The nurse was responsive to the person's predicament and arranged for the person's doctor to visit to help with pain relief. The doctor arrived shortly afterwards and arranged for additional pain relief for the person.

People who used the service mainly spoke positively about the recreational and leisure activities provided. One person said: "Sometimes a singer comes in but there's not much else to do. I sit in my room most of the time. I've got my television. I don't mind being on my own". Another person commented: "There are activities. I can take part in the exercise and music. The activities lady has a hard job but she always tries and fits in what anyone likes. She comes to your room and helps you down to the lounge". We saw a religious service was organised each month, one person told us they enjoyed attending these services. The deputy manager told us very few community activities were arranged because of the location of the service and the lack of transport. This meant that some people did not have the opportunity to go out of the service or to visit local places that may be of interest to them.

The provider had a complaints procedure. People we spoke with and their relatives told us they would speak with the registered manager or the nursing staff if they had any concerns. A person told us: "If you have any worries the manager is available". Another person said: "I know where they are if I have any complaints". Staff told us they would speak with the manager if they had any complaints. Staff were aware of the whistleblowing procedures if they felt unable to speak with the manager. We saw the action the regional manager had recently taken when a person had cause to complain on behalf of their relative who used the service.

Inadequate

Is the service well-led?

Our findings

The regional support manager and deputy manager told us that audits and checks of the quality and safety of the service were completed at regular intervals throughout the year. These included audits of medication, accidents and incidents, falls, pressure areas, care and support plans equipment and the environment. However we identified concerns in medication, care and support plans, falls, accidents and incidents, which had not been recognised through the auditing process.

We had concerns with the way topical medications were administered and recorded and could not be assured that people received their creams and ointments correctly and to the prescribing instructions. We saw topical medication administration records were not sufficiently completed to inform staff. For example on some records there were no directions for application and many gaps on the record when the topical creams were prescribed to be applied twice a day. This meant that some people may not have received their prescribed medicines in the correct way. The clinical leadership was ineffective as the systems in place did not identify these omissions.

We saw conflicting information in care and support plans which meant people were at risk of inconsistent and unsafe care and support. For example, the level of risk and the level of need differed for people at high risk of falls. Staffing levels were determined using the dependency needs of people who used the service. The conflicting and inconsistent assessments would not give an accurate reflection of people's dependency needs to ascertain adequate staffing levels. Staffing numbers were based on these unreliable assessments, we did not see that consideration to the layout of the building had been included. This meant some people were at risk of receiving unsafe or unreliable care and support.

People told us the service was short of staff, we saw that people experienced delays in receiving the care and support they required in a timely way. People told us that they regularly waited for over an hour to be supported to the toilet. We saw a person waited for an 11 hour period before they were offered any food. This person was unable to make their needs fully known as they had difficulty with communicating. This meant that some people's health and well-being were not being supported.

In addition and as part of the monitoring process the manager completed a daily walk around the service which included a checks people's medication records. People were asked how they were and if they needed anything and the manager observed how the staff supported people. The daily walk round did not identify that people experienced delays in receiving staff support and people were not receiving their topical medicines as they had been prescribed.

A daily flash meeting was held each day with the various departments within the service. These were brief meetings that included the nursing staff, catering and ancillary staff to discuss any issues that may arise in relation to the daily running of the service. The regional managers checked the flash meeting records as part of their audit process. We saw brief comments were recorded on the food, the activity planned and any concerns relating to people who used the service. A customer satisfaction survey was completed in 2015, the results were analysed. Some people indicated on the survey that it took a long time for staff to answer

the calls bell. One person made a comment regarding a two hour wait at lunchtime. From our discussions with people who used the service and our observations it was evident that people continued to experience delays in receiving the support they needed. This meant the provider had not been responsive to people's feedback about their care.

The provider had not followed the principles of the MCA and DoLs to ensure decisions were made in people's best interests. Important decisions were being made on behalf of people who used the service, they were excluded from the discussions. People were being restricted of their liberty and freedom without the legal authorisation to do so. There was a lack of understanding of the legislation to ensure all legal requirements were met.

The above evidence showed the provider did not have effective systems to identify and promptly respond to concerns with staffing levels, delays in people receiving the support they required or managing risks to people's health, safety and wellbeing.

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

We saw from records that people had been assessed as being at risk of falls. One person had fallen unwitnessed on four occasions. This person was unable to mobilise independently and required two staff to support them with moving. It was recorded the person was mainly nursed in bed. We saw other people who had sustained unexplained injuries. We saw one person had sustained a bruise and a substantial injury to their arm; the cause was recorded as 'unknown'. The deputy manager offered a possible explanation but confirmed they did not refer this or the unwitnessed falls to us. It is a legal requirement of the registered person's registration that they must notify the Commission without delay of any incidents which affect the health and well-being of people who used the service.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager was not at the service. The deputy manager had been managing the service in the registered manager's absence with the support of the regional support managers. One visitor told us: "The staff respect the registered manager, she runs a tight ship. It's worked well since she's been off. The staff work well together. There's a nice friendly atmosphere". A person who used the service told us: "The manager is off work at the moment but is very approachable when she's here. If you have any worries she's available". Staff told us they felt generally well supported by the management team. One staff member told us the issue with staffing levels had been discussed with the management team and added: "Nothing seems to get done though". We saw that staff were very busy attending to the care needs of people and were watchful of the times when people needed repositioning in bed. This had a detrimental effect on the people who were less dependent on staff. Staff did not always have the time to provide person centred and individualised safe and effective care to all people who used the service.

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 was not fulfilling their legal obligations of their registration and did not notify us of serious incidents and events.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was failing to ensure people using the service, and those lawfully acting on their behalf, have given consent before any care or treatment is provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service was failing to make sure that providers deploy enough suitably qualified, competent and experienced staff to enable them to meet all other regulatory requirements described in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service was failing to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment.

The enforcement action we took:

We issued a warning notice to ensure improvements would be made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was failing to make sure that providers have systems and processes that ensure that they are able to meet other requirements in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A).

The enforcement action we took:

We issued a warning notice to ensure improvements would be made