Care Consortium (Biddulph) Limited

Springbank Nursing Home

Inspection report

Mill Hayes Road
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ST8 7PS
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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Inadequate**
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

We inspected Springbank Nursing Home on 13 October 2015. The inspection was unannounced. At our last inspection on 30 May 2013, we found that the provider was meeting the required standards. During this inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration Requirements) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The service is registered to provide accommodation and personal care for up to 42 people. People who used the service were over 65 years old and have physical and/or mental health diagnoses. At the time of our inspection there were 39 people who used the service.

The service had a manager but they were not registered with us (CQC). 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

Summary of findings

meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. We requested that the manager registered with immediate effect.

Risks to people's health and wellbeing were not consistently identified or managed to promote their safety. We found there were not always enough staff available to deliver people's planned care or keep people safe.

Effective systems were not in place to ensure medicines were administered in a consistent and safe manner at a time when people needed them.

People did not always get the support they needed to eat and drink. Systems to monitor people were receiving sufficient amounts to eat and drink were not always in place. This meant some people's nutritional needs were not met.

People were not always supported to have their care in an environment that protected their privacy and dignity.

People and their relatives were not always involved in planning their care. Staff had a varied knowledge of people's care preferences. This meant that people were at risk of receiving inconsistent care.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that poor care was unable to be identified and rectified by the manager and provider.

People were not always protected from potential abuse because staff did not recognise some incidents that may be considered as alleged abuse.

People told us they were treated with care and given choices. However, improvements were needed to the way the provider gave choices at lunchtime.

People's health and wellbeing needs were monitored and advice was sought from health and social care professionals when required. However, we saw that the advice received was not always followed to ensure their health needs were met effectively.

When people did not have the ability to make decisions about their care, the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were followed. These requirements ensure that where appropriate, decisions are made in people's best interests when they are unable to do this for themselves.

Staff received training. However, we found that improvements were needed to ensure that the quality of the training followed the correct guidelines. There were no systems in place to ensure that staff understood and followed the training supplied.

People were given the opportunity and supported to be involved in social and leisure based activities.

People knew how to complain about their care and complaints were managed in accordance with the provider's complaints policy.

People and their relative's feedback was gained and we saw that systems were in place to address feedback to improve people's care experiences.

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?

Inadequate

The service was not safe. Risks to people's health and wellbeing were not consistently identified or managed to promote their safety. We found there were not always enough staff available to deliver people's planned care or keep people safe.

Effective systems were not in place to ensure medicines were administered in a consistent and safe manner at a time when people needed them.

People were not always protected from potential abuse because staff did not recognise some incidents that may be considered as abuse.

Is the service effective?

Requires improvement

The service was not consistently effective. People were not always supported to eat and drink sufficient amounts and their nutritional needs were not consistently monitored.

Staff received training. However, we found that improvements were needed to ensure that the quality of the training followed the correct guidelines. There were no systems in place to ensure that staff understood and followed the training supplied.

People's health and wellbeing needs were monitored and advice was sought from health and social care professionals when required. However, we saw that the advice received was not always followed to ensure their health needs were met effectively.

Is the service caring?

Requires improvement

The service was not consistently caring. People were not always supported to have their care in an environment that protected their privacy and dignity

People told us they were treated with care and given choices. However, improvements were needed to the way the provider offered choices at lunchtime.

Is the service responsive?

Requires improvement

The service was not consistently responsive. People and their relatives were not always involved in planning their care. Staff had a varied knowledge of people's care preferences. This meant that people were at risk of receiving inconsistent care.

People were given the opportunity and supported to be involved in social and leisure based activities. People knew how to complain about their care.

Summary of findings

Is the service well-led?

The service was not consistently well led. There was a manager at the service, but they were not registered with us (CQC). The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that poor care was unable to be identified and rectified by the manager and provider.

People and their relative's feedback was gained and we saw that systems were in place to address feedback to improve people's care experiences. Staff felt supported to undertake their role and were able to approach the manager with any concerns they had.

Requires improvement

Springbank 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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 October 2015 and was unannounced.

The inspection team consisted of two inspectors.

We reviewed the information we held about the service. This included notifications that the provider is required to send us under the Health and Social Care Act about events that had happened at the service. For example, serious injuries and safeguarding concerns. We also considered information we had received from commissioners and other professionals involved with the service.

We spoke with seven people, two relatives and six care staff and the manager. We observed care and support in communal areas and also looked around the service.

We viewed five records about people's care and records that showed how the home was managed. We also viewed five people's medication records.

Inadequate

Is the service safe?

Our findings

People's risks had been assessed. However, we found that people's risk assessments had not always been acted on to lower the risk of harm. One person had been assessed as a high risk of pressure damage and some staff we spoke with told us that this person had a pressure relieving cushion that they used, which would ensure the risk of pressure damage was lowered. Other staff told us that this person was not at risk of pressure damage. On the day of the inspection this person had not been supported to use a pressure relieving cushion. The records we viewed showed that this person did not currently have a pressure sore, but was at high risk because they had previously had a pressure sore. The records did not detail what support or equipment was needed to lower the risk of pressure damage. The nurse told us, "I agree, we do need to put a skin integrity care plan in place for this person". This meant that this person was at risk of receiving inconsistent care and treatment.

We saw that one person had been assessed as requiring a stick to mobilise and their care plan stated that they required staff supervision with their mobility at all times. We observed this person moving around the dining area with no staff supervision. Staff we spoke with told us that this person was independent, was not at risk and did not need any equipment when they moved around the service. Staff were unaware that this person had recently had two falls and the records we viewed had not been updated to ensure this person was protected from the risk of further falls. We asked staff about the mobility needs of four other people and the explanations they gave did not match the five risk assessments we had viewed. This meant that people were at risk of unsafe care because risk assessments were not always being followed correctly by staff or updated when people's mobility needs had changed.

We found that medicines were not managed in a safe way. During the morning medicine administration round we saw that the nurse on duty was unsure of who people were when administering medicines. The nurse asked people who they were and on one occasion we saw that one person was nearly administered medicines that had been prescribed for another person, before the nurse checked with another member of staff. We saw that the morning medicines were still being administered at lunchtime. One person's morning medicine was prescribed to be taken with or after food and they did not receive their medicine until 11.40a.m. We saw that this person had their breakfast at 9.15a.m and this meant they received their medicine two hours and 25 minutes later than it had been prescribed. The Medicine Administration Records (MARs) we viewed did not show the time that the medicines were administered, which meant people were at risk of receiving their medicine without the required space of time between them. We asked staff why people were not receiving their medicines on time. One staff member said, "It doesn't normally take this long. We have used agency staff but they are slow because they don't know everybody like the permanent nurses do". We viewed MARs and checked these against the medicines that the service had in stock. We checked five people's MARS and four of these records showed that there were more medicines in stock than recorded on the MARS. The nurse on duty was unable to explain why the amounts did not balance. We also found that where people were administered 'as required' medicines, which varied in dosage, there were protocols in place which detailed the amount to be administered. We saw that when people had received 'as required' medicines the amount administered had not been recorded on the MARs. This meant we could not be assured that people had received the correct amount of medicines they had been prescribed.

The above evidence shows people were not always supported in a way safe way because appropriate actions were not taken to manage risks effectively. This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the staff were always busy and they had to wait for their needs to be met. One person said, "I have waited 45 minutes for staff to help me. It's okay I know they are busy". Another person said, "I have waited 20 minutes for hep to go to the toilet, It's not nice I feel uncomfortable". We saw that staff were not always available to meet people's need and protect their safety during the morning. People who needed mobility aids to lower their risk of falling were observed in the dining room leaving their aids to move chairs as they couldn't get past to get to their preferred table and there were no staff available to support them. We saw two people ask the kitchen assistant if they could be supported to use the toilet but they were told they needed to wait for staff to come and one person became restless, trying to push themselves away from the table. One person needed encouragement to eat and drink

Inadequate

Is the service safe?

sufficient amounts, but there were no staff available to provide this support. This meant that there were insufficient staff available in a morning to keep people safe and meet their individual needs.

Staff told us that mornings were very busy and they struggled to provide support to people when they needed it. One member of staff said, "I don't think there is enough staff in a morning. The problem is when some people are waiting to be supported to get out of bed and there are also people who need supporting in the dining room with breakfast". Staff told us that the number of staff at other times was sufficient and they were able to meet people's needs in a timely way. We were told that the service was a staff member short on the day of the inspection but arrangements had not been put in place to cover this shortage. We fed our concerns back to the manager who told us they had already recognised the need for another member of staff in a morning. Plans were in place to increase the staffing on the next week's rota, but this meant that the staffing levels had not been changed in a timely way to ensure that people were safe.

People told us that staff treated them well. Relatives told us that they were happy with the way their relative was treated. Staff told us what constituted abuse and the actions they would take to if they suspected that a person was at risk of abuse. One member of staff said, "I would report any concerns to the manager or nurse on duty straight away. I know we have a whistleblowing policy too if I needed to use it". However, we raised concerns about a person who used the service that had unexplained wounds to their lower body. We asked staff what had caused these, but no one could tell us how this had happened. We looked at the records and there were no details of how these wounds had been caused. We also saw that one person had an accident recorded which stated they had fallen off their bed when they were being supported to move by staff using a slide sheet. We did not see any further investigation into this incident or discussion with staff to ascertain why this had occurred. These two incidents required consideration and possible referral to the local safeguarding authority, but this had not been identified by the manager. The manager told us that they would look at these incidents and refer to the safeguarding authority.

We saw that the provider had a recruitment policy in place and the manager undertook checks on staff before they provided support to people. These checks included references from previous employers and checks which ensured that staff were suitable to provide support to people who used the service.

Requires improvement

Is the service effective?

Our findings

We saw that some people needed their food and drink intake monitoring and were assessed as requiring supplements which ensured they maintained a healthy weight. We saw that one person was not drinking enough fluids and staff were not available to support this person with their drinks. This person was also prescribed supplements to help maintain their weight. We saw that the supplement provided at breakfast had been left unfinished and this was taken away by staff. We checked the care records, which identified that this person needed encouragement to eat and drink. We saw staff brought drinks to this person but there was no encouragement given and this person did not drink what was provided. We saw that monitoring was in place for this person's food intake but there were no records that showed whether this person was drinking sufficient amounts. The records we viewed showed that this person had continued to lose weight. We told a nurse on duty who said, "There should be a fluid chart in place, I'll make sure one is put in place". This meant that this person was not being supported effectively and their nutritional needs were not being monitored or recorded as required.

Despite the concerns we raised people told us that they enjoyed the food at the service. One person said, "The food is very good. I always enjoy it". Another person said, "The choice of food is good". A relative told us that their relative enjoyed the food and they had gained weight since they had been at the service. We saw that the food provided looked appetising and aids such as plate guards were provided, where people were able to eat without staff support.

People using the service and relatives told us that they accessed health services and we saw that people had been referred to specialist health professionals when required. However, we found that the advice gained from health professionals had not always been followed. For example; one person had been informed that they would benefit from physiotherapist input and this would be arranged by an external professional. There had not been any contact for four weeks from the external professional and this had not been followed up by the manager to ensure this person received the external support required.

Staff we spoke with told us they had received training to carry out their role and they had access to training updates. However, there were no systems in place to monitor the effectiveness of the training. We saw that staff had received training in moving people who were unable to move independently. We observed staff moving people in a way that could cause injury to people such as, under arm lifting when supporting people to stand and an inappropriate sling was used to hoist a person to their chair. We asked staff about these concerns and they told us this was how they had been trained to support people to move. The manager told us and we saw that there were plans in place to update staff knowledge and skills by providing further training.

Some people who used the service were unable to make certain decisions about their care. The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out requirements to ensure that decisions are made in people's best interests, when they lack sufficient capacity to be able to do this for themselves. Most staff were able to explain the basic principles of the Act and we saw that mental capacity assessments were completed when required. The manager had a good understanding of their responsibilities with regards to Deprivation of Liberty Safeguards (DoLS) to ensure that people were not unlawfully restricted. We saw that some people had DoLS in place which set out the support required to keep people safe in the least restrictive way.

Staff also told us that they had received an induction when they started to work at the service. We spoke with a newly employed member of staff. They said, "The induction has been good. I have undertaken various training and I am now shadowing experienced members of staff before I am able to provide care to people". Staff told us they received support and supervision meetings. Staff felt these were helpful and gave them the opportunity to discuss any concerns and ways that they could develop in their role.

Requires improvement

Is the service caring?

Our findings

We found that people's dignity was not always considered. We observed staff on two occasions asking people to consent to treatment in a way that did not consider their dignity. For example, one person was administered eye drops at the dining room table where this person was having breakfast with three other people. This person did not like the eye drops and became anxious in front of other people which did not maintain their dignity. Another person who was sitting at the table had a sample of blood taken from their finger so that their blood sugar levels could be assessed. The same person was asked if the visiting professional could administer their medicine whilst in dining room. This person was declining the treatment and their refusal of the treatment was being influenced by comments of other people who used the service that were sat at the same table. After a period of five minutes this person was then supported to their bedroom to have their medicine. We asked the staff member if they thought this was dignified for this person, they said, "No it's not right and I understand it wasn't dignified. It should have been carried out in private". This meant that people were not always supported in a way that gave them privacy and protected their dignity.

The above evidence shows people's privacy and dignity was not always maintained. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff were happy with the way the staff supported them. One person said, "The attention is good". Another person said, "Staff treat me fairly" and, "Staff are nice". Relatives told us that the staff always treated people in a kind way and they were happy with the way staff cared for their relative. People and relatives also told us that there were no restrictions on visitors and they were able to see their family and friends at any time. We saw that staff spoke with people in a caring way, however, care staff were busy and the interactions were quite rushed. For example, staff did not have time to sit and talk to people giving them time and making them feel that they mattered.

People told us that they were given choices by staff. One person said, "I am asked what I want and I like to stay in my room, which the staff let me do, they listen to me". Another person said, "The staff ask if they can help me. I choose what I want to do and if I want to join in with activities". We saw people being given choices in the activities that they wanted to do and if they wanted to be involved. Where people chose not to be involved their wishes were respected. People told us and we saw that people were dressed individually and were given choices in the clothes that they preferred to wear. We observed how people were supported with choices at breakfast and lunch. We saw that people were offered a varied choice of meals at breakfast and staff provided people with their chosen meal. However we saw that people were not supported to make choices at lunch. For example; people had pre-ordered their meal on the previous day, but they were not offered a chance to change their mind with their meals or informed of the meals that were available.

Requires improvement

Is the service responsive?

Our findings

Relatives told us that neither nor the person who used the service had been involved in reviews of their care. One relative told us they were not informed of any changes to their relative's needs or health unless they noticed a change and asked staff about the changes. They said, "If I ask then staff tell me about changes, but if I didn't ask I wouldn't know. It would be good if I was updated when I visited". We did not see evidence that people or their relatives were involved in the review of their care.

We saw that some reviews were out of date and where people's needs had changed the records had not been updated to reflect this. For example; one person had been receiving treatment for a pressure sore, we asked staff about this who told us that this had healed and they no longer needed to treat this area. The records we viewed had not been reviewed to show that there was no longer a risk to this person and what support was required to prevent a future occurrence.

People did not always have their preferences in care met because staff were not always available to provide this. One person asked staff for their glasses, and for their cardigan as they were feeling the cold. We saw this person waited for a significant amount of time before staff provided this person with the items that they needed. Another person told us that staff responded to the care bell when they wanted to use the toilet. However, they told us that staff asked what they needed, turned the call bell off on two occasions saying they would return. This person told us that they had to wait a significant amount of time, which made them feel uncomfortable. We fed this back to the manager who was unaware of these concerns but told us that they would look into this and speak with staff.

Staff we spoke with had varied knowledge of people's preferences in care. We found that some staff were aware of people's likes and dislikes and knew people well. However, the agency staff member on duty was not aware of people's preferences in care. For example; an agency staff member was unaware of a person's preference to have their breakfast in their room and was observed asking other people who used the service why they weren't at breakfast. Care staff we spoke with told us that they did not view care plans on a daily basis and relied on the information passed on at the handover meetings. One member of staff said, "We don't look at care plans regularly, we fill in the charts on a daily basis, I would look at a care plan if I wanted to clarify what has been said at handover".

The above evidence shows people's privacy and dignity was not always maintained. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that there was plenty for them to be involved in throughout the day. One person said, "There is lots of variety such as; films, music and talks. It's very good". Another person said, "There are singers and activities on offer but I prefer to go out with my friend. I like to stay in my room and work on my embroidery. Staff come and have a chat sometimes". The provider employed two activity staff who provided a varied activity programme for people to be involved in. We saw people were encouraged to be actively involved in the activities on offer in the communal areas of the service. The activity staff member kept people engaged and interested in the activities we saw on the day, which included a game of 'play your cards right', reminiscence discussions and the use of an interactive computer package that provided a visual aid to the discussions. However, we observed that people who were unable to leave their rooms did not have the same opportunities to interact with staff. The manager told us that one of the activity staff had accompanied a person on an appointment and this staff member would normally be available to provide one to one interaction with people in their bedrooms, but they were unable to on this occasion.

People we spoke with told us they knew how to complain and they would inform the manager if they needed to. One person told us, "I tell them [staff] if I'm not happy and they listen to me". Relatives we spoke with also knew how to raise a complaint and told us that they were comfortable raising any issues with the manager. One relative said, "I would complain if I wasn't happy, I'd speak to a nurse". The provider had a complaints policy in place which was available to people who used the service, relatives and visitors. The manager had a complaints log in place, which showed that complaints had been investigated and responded to in line with the provider's policy.

Requires improvement

Is the service well-led?

Our findings

The service had a manager in place but they had not registered with us (CQC). We had informed the provider that they were required to have a manager that was registered as this was a condition of their registration. The manager told us that they had previously registered with us and thought that their registration was current. We advised the manager that an application was required and we would expect this to be actioned by themselves and the provider with immediate effect. This had not been received at the time of writing the report.

The provider had not met the condition of their registration to have a registered manager in place. This is a breach of Regulation 5 of the Care Quality Commission (Registration Requirements) Regulations 2009.

The provider has a duty to notify us (CQC) of any incidents that had happened at the service, which enables us to monitor the service. For example; deaths, serious injuries, alleged abuse and when a Deprivation of Liberty Safeguards (DoLS) had been authorised. We found that the manager had notified us of any deaths at the service but we had not been notified of any other incidents. For example; the local safeguarding authority had advised us on four occasions over a 12 month period of allegations of abuse and we had not been notified about these by the manager. People who used the service were also been cared for with DoLS that had been authorised by the local authority but we had not been notified of these restrictions by the manager. The manager told us that this had been the responsibility of a previous member of staff and they had not been aware that they had not carried this out.

The provider had not notified the commission of incidents as required. This is a breach of Regulation 18 of the Care Quality Commission (Registration Requirements) Regulations 2009.

We asked the manager for evidence of how they assessed and monitored the quality of the service provided. We found that there were no systems currently in place that ensured people were receiving a good service and where we had identified concerns the manager was unaware of these. We identified that there were concerns with the accuracy of medicines stock and the manager told us that there were not currently any systems in place to monitor how medicines were managed. We also saw that people's weight and fluids were not been monitored regularly as stated in their care plans. For example; one person who was a high risk of dehydration had not been monitored effectively and the manager was unaware of this.

We also saw that incidents that had occurred at the service had not been analysed and actions had not been taken to lower further risks to people. For example, we saw that one person had suffered a number of falls, but there had been no actions put in place to lower the risk of further occurrences. We found that accidents had been recorded but these had not been analysed or monitored by the manager to assess if there were any common trends, such as times or areas around the home. The manager told us they were unaware of these incidents, but they had new system to monitor accidents; however this had not been implemented at the time of the inspection. The manager told us that they had recently recognised they did not have systems in place to assess and monitor the service and the provider had employed an external consultant to help with the implementation of monitoring systems. We saw templates for monitoring and assessing risks to people which included incident and medicine audits. However, these had not been implemented and we could not be assured that these would be effective.

We asked the manager how they assessed the staffing levels against people's dependency needs. They told us that this was completed by the nurses and the information was forwarded to the operational manager to work out the staffing required. The manager told us that they had identified that an extra member of staff was required in the morning to meet people's needs. There were plans for another member of staff to be on duty commencing the week after our inspection . We saw that there were not enough staff available and people were at risk of unsafe care. This meant that although this had been identified as a risk timely action had not been taken by the provider to ensure sufficient staff were available.

The above evidence shows that effective systems were not in place to assess, monitor and manage risks to people's health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people and their relatives had been asked to complete satisfaction surveys. The results from the survey had been collated by the manager and where concerns had been identified by people or their relatives an action plan

Requires improvement

Is the service well-led?

had been put in place to make improvements. For example; people had expressed they would like to be involved in resident/relative meetings. We saw that the manager had arranged for a meeting to be held at the service on the 26 October 2015 in response to the feedback that they had gained from people and relatives.

People and their relatives told us the manager was approachable and they would speak with them if they had any concerns. Staff also told us that the management was supportive and they could approach them if they had any concerns. One staff member said, "I can raise any concerns if I need to. I would go to the nurses if I had any problems, and I could also approach the manager if I needed to". Another member of staff said, "I feel supported in my role, I have supervisions which are useful and team meetings regularly". We saw that staff meetings had been held and there was a schedule in place for future staff meetings.

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 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People's care was not always provided in accordance with their preferences and assessed needs. Regulation 9 (1) (a) (b) (c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not always treated in a way that took account of their dignity and privacy. Regulation 10 (1) (2) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 5 (Registration) Regulations 2009 Registered manager condition **The provider had not met the condition for a registered manager to be in place as specified in the registration with the commission. Regulation 5 (1) (b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered person had not notified the Commission without delay of the incidents which occurred at the service in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity. Regulation 18 (1)**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People did not always receive safe care and treatment because risks to their health and wellbeing were not assessed and managed appropriately. Medicines were not managed safely. Regulation 12 (1) (2) (a) (b) (e) (g)

The enforcement action we took:
We served a warning notice to the provider telling them to make immediate improvements to the quality of care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have systems in place to ensure that risks to people's health and wellbeing were assessed, monitored and managed effectively. The provider did not have systems in place to assess, monitor and improve the quality of care people received and accurate records of people's required care and treatment were not always kept. Regulation 17 (1) (2) (a) (b) (c) (f)

The enforcement action we took:
We served a warning notice to the provider telling them to make immediate improvements to the quality of care.