Mrs S Hart

Springfield House Retirement Home

Inspection report

Springfield Avenue
Morley
Leeds
West Yorkshire
LS27 9PW

Tel: 01132521969

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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 23 February 2016 and was unannounced. At the last inspection in January 2014 we found the provider was meeting the regulations we looked at.

Springfield House Retirement Home provides care and support for up to 22 older people. The service had an individual who is a '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.

During the inspection there was a pleasant and friendly atmosphere. People knew others they lived with and the staff who supported them. They enjoyed the company of staff who often sat and chatted to them. Through our observations and discussions we found there were enough staff to keep people safe.

People were offered a variety of meals. Everyone told us the food was good. It was often described as "great" and people said there was plenty of choice.

People told us the service was caring and they received person centred care. The service used an electronic care planning system. Some aspects of care planning and assessment were effective but other areas needed developing to ensure people received appropriate and consistent care. The management team recognised they were not using the electronic system to its full capacity and planned to utilise this better.

People were comfortable in the environment, which was warm, and generally clean and well-furnished. Individual rooms were personalised. We noted a small number of areas that needed addressing to mitigate risk. For example, security on the front door and the electrical installation certificate had expired.

People had regular health checks and the service had recently agreed to participate in a scheme to help improve access to healthcare for people living in care homes. However, we found medicines were not always managed consistently and safely. Some people were not given their medicines as directed by the prescriber, for example, before food.

The service had a flexible approach in relation to staff roles which meant that everyone who worked at the home was able to carry out care responsibilities. People we spoke with said this worked well. There was a low turnover of staff and no new staff had been recruited for nearly two years. The provider had a recruitment procedure but this did not cover the key steps that should be followed when new staff were recruited.

People who used the service could make decisions about their care, such as choosing where to spend their time and whether to engage in activities provided.

Staff received training and supervision to help them understand their roles and responsibilities. Staff told us

they felt well supported and enjoyed working at the home.

Staff told us they were confident people received good care and knew how to safeguard people from abuse. They gave examples of how they promoted choice and provided opportunities for people to make decisions. However, some staff were unclear about the key requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Information was displayed to help keep people informed. This included how they could access additional services and what they could expect when living at Springfield House Retirement Home.

The management team were friendly and approachable. They had created a positive culture and set high standards around caring for and respecting people who used the service. However, during the inspection we identified they were not consistently assessing, monitoring and mitigating risk, and the systems they had in place were not always operated effectively. The care manager and owner were both very receptive where suggestions for improvement were made.

People had no concerns about their care but were informed how to make a complaint if they were unhappy with the service they received.

We found the home was in breach of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 always safe.

Medicines were not managed consistently and safely.

Systems were in place to help keep people safe, which included safeguarding them from abuse.

There were enough staff to keep people safe. The service had a flexible approach in relation to staff roles which meant that everyone who worked at the home was able to carry out care responsibilities.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were met by staff who had the right skills, competencies and knowledge.

People were encouraged to make decisions about their care and support. However, gaps in staff knowledge relating to the key requirements of the Mental Capacity Act 2005 could result in people's rights being overlooked.

People enjoyed the food and were offered a varied diet. People received appropriate support with their healthcare.

Is the service caring?

Good

The service was caring.

People told us they were well looked after and the staff were caring. They were happy with the service they received.

Staff knew people well, which included their history, family relationships, and likes and dislikes.

Information was made available to people to keep them informed about the standard of care they could expect and how to get additional support.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People told us they received person centred care. Some aspects of care planning needed developing to make sure they consistently reflected people's needs.

People enjoyed a range of social activities

Systems were in place to respond to concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

People who used the service and staff spoke positively about the management team. They told us the home was well led.

Everyone was encouraged to put forward suggestions to help improve the service.

The management team did not have effective systems and processes for monitoring the service but had started developing these; however these needed further development these were not always effective.

Springfield House Retirement 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.

This inspection took place on 23 February 2016 and was unannounced. Two adult social care inspectors and an expert-by-experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed all the information we held about the service, and contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

At the time of our inspection there were 17 people using the service. During our visit we spoke with people who used the service, relatives, three members of staff, the care manager and the owner. We looked at areas of the home including some people's bedrooms and communal rooms. We spent time looking at documents and records that related to people's care and the management of the home. We looked at four people's support plans.

Requires Improvement

Is the service safe?

Our findings

We looked at the systems in place for managing medicines in the home, which included reviewing Medication Administration Records (MARs), medicine stock and other records that related to medicines. We found systems were not always effective.

Some people's medicines had specific instructions but these were not followed. For example, several people were prescribed medicines that should be administered between 30-60 minutes before food, however, they were given their medicines with or after their breakfast. This could reduce the medicine's efficacy.

When we looked at MARs and the stocks of medicines stored in bottles it was not possible to account for all medicines because staff had not accurately recorded when new stock was delivered. One person was prescribed a medicine where they could take one or two tablets but it was not clear from the MAR whether they had been given one or two. The person did not have written guidance to help staff know when to administer one or two tablets. MARs were generally printed by the dispensing pharmacist. However, one MAR was handwritten. The provider's medication policy stated these must be signed by two staff; the one we reviewed had not been signed.

One person's MAR showed they were prescribed a pain relief gel that they self-administered; other medicines were administered by staff. The person did not have any information in their assessments or care plan to show they were looking after any of their medicines.

Some people were prescribed medicines to be taken only 'as required' e.g. painkillers that needed to be given with regard to the individual needs and preferences of the person. People did not have written guidance to help staff understand why the person required the medicine or when to administer. One person had eye drops that stated they should be 'used as required'. We saw that for 11 of the 15 days before the inspection these were administered four times a day. There was no guidance or explanation why the eye drops were being used so frequently. One person had a protocol which stated the person was prescribed paracetamol as required but when we looked at the person's medication administration records (MARs) they were prescribed it three times daily. One person was prescribed a liquid medicine once a day but staff had signed to show this had been administered twice a day.

The provider's medication policy provided guidance on some aspects of the safe administration of medicines, however, it was not based on current legislation and did not cover some important areas of managing medicines in care homes. There was no reference to the National Institute for Health and Care Excellence (NICE) guidance, 'Managing medicines in care homes guideline (March 2014)'. The policy should but did not cover areas such as 'helping residents to look after and take their medicines themselves' and 'care home staff giving medicines to residents without their knowledge(covert administration)'.

We found there was not proper and safe management of medicines. This was in breach of Regulation 12 (2) (g) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff who administered medicines told us they had completed medicines training and competency checks to ensure they were administering medicines safely; the training and competency records we looked at confirmed this.

When we asked people if they felt safe living at Springfield House Retirement Home they told us they did. Information about 'keeping adults safe from abuse' was displayed in the home and safeguarding had been discussed at meetings; this helps ensure people know how to stay safe and report any concerns. Staff we spoke with told us people were safe. They said systems were in place to protect people from avoidable harm and potential abuse. Staff we spoke with said they had undertaken safeguarding training and the training records we reviewed confirmed this. Everyone said they would report any concerns and knew how to do this. They were confident if they reported a concern to the management team they would deal with it promptly and appropriately.

We looked around the home as part of our inspection, which included some bedrooms, bath and shower rooms, and communal living spaces. We saw people were comfortable. The home was warm, and generally clean and well furnished. Good hand washing facilities and hand sanitation was available throughout. People's rooms were personalised. We noted a small number of areas that needed addressing to mitigate risk. The lino in one storeroom floor was torn and a trip hazard for staff. One first floor window did not have a restrictor fitted. A number of internal doors whilst locked were not secure as the keys were kept on a hook screwed into the door frame above the door. The home's front door was not locked and people could freely access and exit the home. The provider had a policy that stated there was a 'bell that sounded when the front door was opened or closed', however, there was no bell. We spoke to the owner about the areas of risk identified during the inspection and they said they would address these promptly. They said they were reviewing security to ensure there was a balance between safety and giving people the most freedom possible. In the PIR the owner stated they were going to improve security on the front door.

Whilst the home was generally clean, the kitchen required deep cleaning in some areas. The cook and a member of the management team told us this was scheduled in two days. They had identified through their systems that specific cleaning schedules were required which would ensure all areas were cleaned when required. Staff used protective clothing and gloves when they delivered personal care and handling food.

Records showed checks were carried out to make sure the premises and equipment were safe. This included fire safety equipment, the passenger lift, hoisting equipment, gas appliances and legionella testing. First aid boxes were available and whilst checks were not consistently carried out, we found there was a list of what was required and staff had the necessary equipment to deliver effective care in the event of an emergency. The electrical installation certificate had expired. As soon as this was highlighted, the owner arranged for this to be checked by an external agency.

We spoke to staff and they told us they had all had fire training and were familiar with the alarms and fire evacuation procedures. The home had a fire list that detailed the assistance people would require in the event of an emergency evacuation. The list had not been updated to reflect the change to one person's level of assistance status; the owner agreed to ensure the list was updated. One fire exit was blocked by wheelchairs; the owner agreed to move these and keep the exit clear in future.

Staff we spoke with were knowledgeable about the people they supported and potential risks. They gave examples of how they delivered care which helped ensure people were safe. This included using appropriate equipment and involving other professionals where people were at risk. The service used a computerised system for assessing and managing risk. We saw people had a risk profile and areas such as mobility, equipment, nutrition, mental and general health were all assessed. However, we found these were not

always completed robustly. For example, equipment people used for moving and transferring was not assessed. One person was being transferred using a hoist but the sling they used was the wrong size. Another person had fallen and was admitted to hospital. The falls team were involved in their care but their assessment stated they were at moderate risk of falls. People had a 'malnutrition universal screening tool (MUST) which was completed, however, we found that some people who had nutritional problems did not have effective nutritional plans. We discussed our findings with the management team who recognised they were not using the electronic care planning system to its full capacity and planned to develop this.

Through our observations and discussions we found there were enough staff to keep people safe. During the inspection we observed people did not have to wait for assistance and staff had time to sit and chat with people. The care manager explained that staff worked a fixed rota so all staff knew when they were working well in advance, and they had a flexible policy in relation to staff roles which meant that everyone who worked at the home was able to carry out care responsibilities. Ancillary staff often worked additional shifts as care workers and could assist with care duties when they were carrying out their ancillary roles. Care workers also covered some ancillary roles, for example, on the day of the inspection, the cook worked one day a week in the kitchen but also worked as a senior care worker. Staff we spoke with told us the arrangements worked well. They said when they got busy the management team deployed care staff from other roles within the home, and the management team also provided good support.

The service had a very low turnover of staff. The management team said the last member of staff was recruited in July 2014. We looked at recruitment records for staff that had been employed in the last three years and found a range of checks had been completed. This included references, application forms and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records. Two references were obtained for one member of staff but one of these was not from the last employer, which is an important part of the recruitment process to establish satisfactory conduct in previous employment. The care manager said they usually obtained a last employer reference and would ensure this was done with any future recruitment.

We asked about arrangements for checking criminal records for staff that had worked at the service for many years. The care manager said checks had been carried out for all staff but they did not currently have a system in place for renewing checks. They were confident staff would share any changes but said they would ask staff to complete declarations and identify a set timescale where they would renew DBS checks.

The provider had a recruitment policy but this did not cover all key areas of recruitment. The care manager said they had condensed the policy and had a more comprehensive policy that they had previously used. They agreed to review the policy and ensure all key information is included.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with told us they were well supported in their role. They told us they received good support from the management team and colleagues. Staff said the training they received equipped them with the knowledge to do their job well. We looked at the staff training matrix which showed most staff had a recognised care certificate and completed the essential training required to undertake their role within the home. This included; moving and handling, infection control, first aid fire prevention, food handling, COSHH (Control of Substances Hazardous to Health), confidentiality, dignity and end of life care.

The majority of staff had received an appraisal and regular supervision. Supervision is where staff attend regular, structured meetings with a supervisor to discuss their performance and are supported to do their job well. The care manager and some ancillary staff had not received supervision; the owner said they would review these arrangements.

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 they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. (The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).)

Through our observations and discussions we found people who used the service could make decisions about their care, such as choosing where to spend their time and whether to engage in activities provided. Staff were able to tell us how they checked people consented to care. We saw they asked people if they were happy for staff to assist with personal care on the day of our visit.

People's care records clearly stated where they had capacity and could make decisions about their care. For example, one person's care records showed they were 'independent', 'had capacity' and 'involved in care reviews'. Another person had a mental capacity assessment which was assessed as 'low needs'. Their care record stated they could give implied consent. This is consent which is granted by a person's actions and the facts and circumstances of a particular situation.

At the time of the inspection, the service had not submitted any DoLS applications. It was clear from reviewing one person's records they were unable to make some decisions and we were told that a DoLS application relating to personal care was being considered. However, they did not have a relevant mental capacity assessment.

Some staff were unclear about the key requirements of the MCA and DoLS, however, they could give examples of how they promoted choice and provided opportunities for people to make decisions.

People we spoke with, visiting relatives and staff told us the food was good. It was often described as "great"

and people said there was plenty of choice.

We observed lunch, which was pleasant experience for people. It was well organised and people relaxed and enjoyed their meal. The food looked and smelt good, and we saw people were given generous portions. We looked at menus and saw people were offered a variety of meals.

People's care records showed they had regular health checks and support to meet their health needs. The service had recently agreed to participate in a scheme to help improve access to healthcare for people living in care homes. The management team said their experience so far had been very positive and they had already benefitted from receiving extra input from visiting health professionals, such as physiotherapy. They would also be receiving additional training to help staff have a better understanding of health issues associated with old age. The care manager was due to attend a training session about swallowing difficulties.

Good

Is the service caring?

Our findings

When we spoke with people who used the service and visiting relatives, they told us the service was caring. We received positive feedback about the care, quality of staff and satisfaction with the overall service. People who used the service told us they were "well looked after" and "staff go out of their way". Some described staff like "family members". Visiting relatives told us staff provided the "very best care" and staff were "fabulous".

We spoke to a group of people who had formed a friendship group. They told us how happy they were and said the home could "not get better" and it was "wonderful". One person told us they had told their family they were "not going back" or "anywhere else".

People were being given the opportunity to go on holiday in June 2016. The owner discussed this with us and explained they offered this every couple of years. They said staff helped out to make sure everyone had an enjoyable time.

During the inspection we observed relaxed and positive relationships and overheard numerous humorous conversations between staff and people who used the service. People enjoyed the company of staff as well as others they lived with. We saw lots of examples where staff involved people who lived at the home and their relatives. Throughout the day staff were friendly, polite and approachable. All the staff we spoke with told us they enjoyed working at the home. They described the service as "a home from home" and "a lovely place to work". They told us the team worked well together and staff all "helped each other out".

We saw staff chatted to people throughout the day and checked they were ok. We noticed that sometimes, when staff were not present in communal areas, people who used the service requested help for others. There was a handset in the lounge which was linked to the main call bell system, however, on the day of the inspection people did not have access to this.

Staff told us communication at the home was good. They said they were provided with information to make sure they knew people well, which included their history, family relationships, and likes and dislikes. We looked at people's care records and saw there was information about people personal and religious preferences. For instance one person had a preference for "female care worker" recorded. Staff told us that there were regular religious services at the home. We saw evidence that people had the opportunity to discuss their wishes for end of life care.

People were generally helped to be independent and had their preferences met, for example, staying in their room and listening to the radio rather than having a television. Relatives had recently helped organise a large birthday celebration and the person's friends were invited to attend.

The home had information displayed to help keep people informed about how they could access additional services and what they could expect when living at Springfield House Retirement Home. This included, 'the dignity code' and 'advocacy'. Advocacy is a process of supporting and enabling people to express their views

and concerns. A file kept in the entrance contained information about 'living in a care home', 'clothing and laundry', food and meal times' and 'privacy'.

In the PIR the owner told us, 'We select staff for their caring attitudes, and ask residents to help with this. We train staff carefully in the way that we do things and our ethos, and our dignity champion keeps an eye to make sure they keep up standards. We select residents to ensure that they will fit into our home and get along with the current residents, inviting them to spend a day with us before we or they make a decision. We are very strong on Springfield House being the residents' home, while staff and managers are only visitors. Each resident has their own key worker. While they can and do talk to many staff, the key worker is usually the one that they know best.' When we looked around the home, we saw people had cards in their room with keyworker details. This included a photo and a statement that said, 'I will have a chat with you each week to make sure we are caring for you well and to see if you need anything'.

Requires Improvement

Is the service responsive?

Our findings

People told us they received person centred care and we saw throughout the day staff provided individualised care. For example, they provided different support to people at meals times and this was in response to their care needs. Staff we spoke with were knowledgeable about the people they were supporting and understood how to meet their needs. The care they described matched the care that was recorded in the person's care plan.

The service used an effective key worker system to help make sure people received responsive and appropriate care. In the PIR the owner said, 'Each resident has their own key worker. While they can and do talk to many staff, the key worker is usually the one that they know best.' When we looked around the home, we saw people had cards in their room with keyworker details. This included a photo and a statement that said, 'I will have a chat with you each week to make sure we are caring for you well and to see if you need anything'.

The home had an effective and comprehensive care planning computerised system to help make sure people's care needs were assessed and care delivery was planned. We saw staff accessing this during the day to check care records and provide updates. The care manager was responsible for completing the original care plan, which was based on an initial assessment. Staff updated the daily records.

Although we saw some very good information recorded we also saw there were gaps in the way care was being planned. For example, one person's mental health risk assessment identified they had low moods and depression. There was no care plan to show how this area of need should be met. One person's care needs had changed and their care plan stated they needed 'some assistance' with personal care, however, when we reviewed other care records it was evident they needed much more support than the care plan indicated. Although the care plan had not been amended we found staff were providing support that met the person's current needs, however, it could result in care being delivered that was inappropriate or inconsistent because a care plan was not followed. The management team recognised that they were not using the electronic care planning system to its full capacity and planned to develop this. In the PIR they told us they planned to, 'Review our documentation and develop our systems'.

People had toiletries in their room but the service also had toiletries stored in a communal bathroom that were labelled with the initials of the home. This indicated that the toiletries were for general use. There were also two hairbrushes in a bathroom and staff were unable to tell us who they belonged to. Personalised care includes ensuring people have access to their own toiletries. As soon as it was brought to the attention of the owner, all communal items were disposed of.

People told us they enjoyed the activities and on the day we saw different activities were provided. Staff organised group activities such as gentle exercise and were seen spending one to one time with people, for example, they helped one person who was completing a large jigsaw. Some people talked to us about recent trips out. In the PIR the owner told us they involved people who used the service when planning 'activities and trip venues'.

People did not raise any concerns about their care. They told us they would raise any concerns with staff or management. Staff we spoke with knew how to deal with and report any concerns and complaints. Near the entrance of the home we saw a suggestion/complaint /compliment box for people to use.

We looked at the complaint's log and found 15 recorded complaints had been received since the last inspection. We saw these had been responded to. Complaints documentation contained sufficient detail that demonstrated they had all been dealt with effectively and within a reasonable time frame.

Requires Improvement

Is the service well-led?

Our findings

The management arrangements consisted of the owner and a care manager, and they were supported by a deputy manager and senior care workers. We spoke with the owner and care manager who told us the arrangements worked well. They had both been involved with Springfield House Retirement Home for many years and had a well-established mutually respectful relationship and a shared commitment to care. People who used the service, visiting relatives and staff also told us the management arrangements worked well. Everyone was very positive about the management team and said the service was well led.

During the inspection we found there was a welcoming atmosphere. The management team were friendly and approachable. They had created a positive culture and set high standards around caring for and respecting people who used the service. The care manager and owner were both very receptive where suggestions for improvement were made and it was evident they wanted to make sure they provided a service that met key requirements. They engaged with people living at the home and were clearly known to them. Staff we spoke with said the management team worked closely with the team and provided support and guidance where needed.

At the inspection we found there were positive aspects relating to the management of the service but we also found that there was a lack of formal monitoring which had led to a number of gaps and potential risks that had not been picked up by the management team. For example, management of medicines was not effective, and there were gaps in the care assessment and planning processes. Some environmental risks were evident.

We asked to look at audits and checks that were carried out to monitor the service. The management team showed us a new file that had recently been set up. They had identified audits that were going to be completed each month throughout 2016, and included areas such as infection control and medication. In January 2016 they had reviewed fire procedures and in February 2016 they had carried out several mattress audits. There were no audits available for 2015. The management team had recognised that more attention needed to be given to the responsibilities relating to the management, organisation and monitoring of the work involved in delivering a safe quality service. They had set up the new auditing system but acknowledged further work was required.

We looked at accident records and saw these were recorded consistently. A record was made when there were minor incidents, for example, where someone had slipped or was found on the floor, and no injuries were apparent. However, each form had a 'follow up section' that should have been completed but often, was not. This asked if the accident was preventable and if staff had followed the correct procedure, which helps identify how to reduce the risk of repeat events. In January 2016 nine accident forms were completed and in February 2016 there were six. The management team did not have an overview or a system that picked up any trends and patterns. They told us they previously had a system that captured an overall picture of what had happened in the home but no longer completed this. They agreed to re-introduce this to ensure any trends and patterns were identified and managed. At the inspection we identified the registered person was not consistently assessing, monitoring and mitigating risk, and systems and processes were not

operated effectively. This was in breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider asked for the views of people using the service and others to help drive improvement. Resident meetings were held where people had a chance to discuss the service. In January 2016 people talked about food and entertainment/activities. People discussed the menu and put forward suggestions for alternative meals and activities. In September 2015 relatives attended a meeting where they were asked to put forward suggestions to 'make life better'. They talked about safeguarding people from abuse and went through a recent newsletter.

Staff attended 'better meetings' where they discussed what they could do better. Staff were asked to bring ideas and suggestions to improve the service. Formal staff meetings were also held. We looked at meetings from the last meeting in February 2016. They had discussed foot care training, laundry, cleaning, use of hand gel, confidentiality, quality assurance surveys, and communication with family members. Staff we spoke with said, they were given opportunity to share their views and contributed to the running of the home.

The owner told us they had just sent out quality assurance surveys and were waiting for responses, which would then be analysed and suggestions for improvement would be actioned. The owner said they last completed a survey in January 2015, and returned surveys were reviewed and where suggestions were made to improve the service appropriate action was taken.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not have systems for the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not operate effectively systems to assess, monitor and mitigate risk.