Meridian Healthcare Limited

Westwood Lodge

Inspection report

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Wigan WN3 5DJ
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Date of inspection visit: 30 July and 6 August 2015
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

Westwood Lodge is a purpose built home with three units, providing nursing and personal care for up to 76 people. It is situated in a residential area of Wigan close to the town centre. All rooms are single occupancy and have en suite facilities. The home is situated in its own grounds and has gardens with car parking spaces at the front of the home.

We undertook an unannounced focused inspection at Westwood Lodge on 30 July and 06 August 2015. This inspection was undertaken to ensure that improvements that were required to meet legal requirements had been implemented by the service following our last inspection on 17 March and 16 April 2015. At the time of the inspection 72 people were living at the home.

During the inspection on 17 March and 16 April 2015 we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were for; safe care and treatment; person centred care; and good governance. The provider then wrote to us telling us what action they intended to take to ensure they were meeting regulatory requirements.

As part of this focussed inspection on 30 July and 06 August 2015, we checked to see that improvements had been implemented by the service to meet legal requirements. This report covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Westwood Lodge' on our website at www.cqc.org.uk

We found that people were not protected against the risks associated with the unsafe management of medicines. We continued to find concerns in a number of areas.

Summary of findings

The morning medicines round took a long time to complete with one unit finishing the morning medicines at lunchtime. Nurses told us that the way they found medicines organised made it difficult for them to readily locate the medication they were looking for.

We found a lack of information to guide staff how to safely administer 'when required' (PRN) medicines. Medicines records were not always clearly completed to show the treatment people had received. Medicines that were awaiting disposal were not stored according to current guidance.

This is a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; the proper and safe management of medicines, because the provider did not have appropriate arrangements in place to manage medicines safely. CQC are currently considering its enforcement options in relation to this failure, on the part of the provider to meet the regulations.

We found that people were not protected against the risks associated with the spread of infectious diseases. On the day of our inspection, the home reported an outbreak of gastrointestinal disturbance. We could not locate appropriate care plans covering gastro intestinal disturbance for any of the people affected. We found that staff were therefore not provided with clear guidance on how to provide appropriate support in this instance. There was confusion around the management of one person's infection status. The registered manager told us that their understanding was that barrier nursing had been discontinued for this person. However, they were unable to provide documented evidence to support this.

We found the Infection Outbreak Policy did not provide adequate advice and guidance to staff on what actions to take in the event of an outbreak. We could not locate a supply of Personal Protective Equipment (aprons, gloves etc.) for visitors to use to reduce cross infection. We found that none of the affected people had been referred to their GP for medical assessment.

We also found that relatives of people affected by the outbreak had not been informed by the service. We observed three different members of staff who had been supporting people who were subject of the outbreak then walking around communal areas without changing their aprons.

This is a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; assessing, preventing, detecting and controlling the spread of infections, because the provider did have effective systems in place to prevent the spread of healthcare associated infections. CQC has issued a Warning Notice with conditions to be met by 05 February 2016.

During the inspection on 30 July and 06 August, both staff and people who used the service consistently said that staffing levels were insufficient to meet people's needs. Nursing staff informed us that they struggled to get the medication rounds completed in time, which we observed during our inspection on 30 July 2015.

At our inspection on 30 July 2015 we were provided with evidence that the service had sourced training around drug calculations in respect of end of life care (EoL) However, this document was a register of attendance of drug calculations training and did not demonstrate that measurement of specific competencies of registered nurses had been completed. We spoke to one registered nurse who stated that they were not confident in several areas relating to the use of syringe driver equipment that may be used in the delivery of EoL care. We spoke to the registered manager about this issue and identified the shortfall of training and competency audits, which gave rise to our concerns regarding the effectiveness, safety and responsiveness of the provision of EoL care that was delivered by the home.

This is a breach of Regulation 12 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the service failed to ensure all staff providing EoL care had the necessary qualifications, competence, skills and experience to do so safely. CQC has issued a Warning Notice with conditions to be met by 05 February 2016.

During our inspection on 30 July we found a bedroom fire door propped open with a chair and a person inside the room in bed with cot sides up in a very anxious and distressed state. The nurse call buzzer was out of reach of this person. We pressed the nurse call buzzer on several occasions and had to wait for over five minutes in each instance for a member of staff to assist the person. We asked a member of care staff why the person was still in bed and they replied "because they (the person) shout at other residents." The care staff also informed us it was

Summary of findings

easier because of their (the person's) challenging behaviour. We also found that food and fluid charts for this person were in place but contained inconsistent entries. Prevention of pressure sore development charts were also in place but not fully completed.

This is a breach of Regulation 13(4)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because care and treatment of people who use services was provided in a manner that was degrading and included acts that intended to control or restrain a person that was disproportionate to the risk of harm posed to them. CQC has issued a Warning Notice with conditions to be met by 05 February 2016.

We found the service did not effectively monitor the quality of service provision. The service undertook a range of audits of the service to ensure different aspects of the service were meeting the required standards. However, as a result of the continuing concerns we identified around medication, infection control and end of life care it was apparent the service was not effectively assessing and monitoring the quality of service provision.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance, because the service did not have effective governance and auditing systems in place to monitor their service against Regulations 4 to 20A Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC has issued a Warning Notice with conditions to be met by 05 February 2016.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We will report further when any enforcement action is concluded.

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

We found the service was not safe. Medicines were not always given correctly as prescribed and medicines rounds took too long to complete. Medicines records were not always clearly completed to show the treatment people had received. The room used to store medicines was secure. However, the medicines awaiting disposal were not stored according to current guidance.

On the day of our inspection, the home reported an outbreak of gastrointestinal disturbance. We could not locate a supply of Personal Protective Equipment (aprons, gloves etc.) for visitors and staff to use to reduce the potential of cross infection.

Staff and people who used the service consistently said that staffing levels were insufficient to meet people's needs.

Care and treatment of some people was provided in a manner that was degrading and included acts that intended to control or restrain them that were disproportionate to the risk of harm posed to them.

Is the service effective?

Requires improvement

Not all aspects of the service were effective.

We found that the service did not have suitable arrangements in place to ensure staff were suitably qualified to provide End of Life (EoL) Care in respect of necessary qualifications, skills and experience to so safely.

Staff told us they were not confident in several areas relating to the use of syringe driver equipment that may be used in the delivery of End of Life care.

Is the service well-led?

Inadequate

We found the service was not well-led.

We found that the service did not have suitable arrangements in place in respect of effectively monitoring the quality of service provision.

There were inadequate systems in place to identify poor service provision regarding medication management and administration, infection control, the provision of End of Life Care and meeting people's individual needs.

The service had failed to notify CQC about recent medication errors.

Westwood Lodge

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.

We undertook an unannounced focused inspection of Westwood Lodge on 30 July and 06 August 2015. This inspection was undertaken to ensure that improvements that were required to meet legal requirements had been implemented by the service following our last inspection conducted on 17 March and 16 April 2015

We inspected the service against three of the five questions we ask about services during an inspection, which were not meeting legal requirements, these included; 'Is the service safe', 'Is the service effective' and 'Is the service well-led'.

The inspection was undertaken by two adult social care Inspectors, a pharmacist inspector and a specialist adviser in nursing. Before the inspection, we reviewed all the information we held about

the home. We reviewed statutory notifications and safeguarding referrals. We also liaised with external professionals including the local vulnerable adults safeguarding team. We also reviewed the action taken by the provider following our previous inspection, who had written to us explaining what action the service had taken to meet legal requirements.

During the inspection we spoke with the registered manager, the operations director, the senior service quality inspector, five registered nurses, 13 care staff, a visitor to the service, eight people who used the service and the infection control team.

Inadequate

Is the service safe?

Our findings

We visited the home on 02 September 2014 and identified concerns about the safe handling of medicines. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. We returned to the service on 17 March and 16 April 2015 and undertook a full comprehensive inspection of the service. We found the service was still failing to meet regulatory requirements in respect of the safe handling and management of medicines.

As part of this unannounced inspection on 30 July 2015 we checked to see whether improvements had been made and whether the service was now meeting regulatory requirements. We found that people were still not protected against the risks associated with the unsafe management of medicines. We continued to find concerns in a number of areas.

We looked at 13 medication administration records (MAR) during the visit and spoke with the nurses on all three units. The morning medicines round took a long time to complete with one unit finishing the morning medicines at lunchtime. There was a constant stream of interruptions. Nurses told us that the way they found medicines organised made it difficult for them to readily locate the medication they were looking for. Nurses also told us that if medications were missing they had to look in two medicines trolleys, storage cupboards and the fridge to try to locate it which was time consuming. This meant there was a risk people would not receive their medicines at the right time.

Medicines were not always given correctly, as prescribed. We found that three people had no supply of some of their medicines. This included medicines for pain relief, dizziness and an eye drop for dry eyes. A fourth person prescribed a strong pain relief patch had it applied late on five occasions over a five week period. For one person a medicine used to treat rheumatoid arthritis, was signed for as being given, but the recorded stock quantity had not altered indicating it had not been administered.

We found a lack of information to guide staff how to safely administer 'when required' medicines (PRN). (PRN) in the form of a protocol that was readily available to staff. This information should be made available with MAR charts when staff are administering medicines so that it is easy to access in a timely manner. If staff have to leave this task of administering medicines to look for this information in peoples care files it may unnecessarily delay the administration of medicines to people. The recording of whether one or two tablets were given when a variable dose has been prescribed for paracetamol was not always documented. One person was prescribed a sleeping tablet that could be given twice in a week; on one occasion this person was given the medicine three nights in a row. This was not in accordance with the prescriber's directions and placed the health of this person at risk

Medicines records were not always clearly completed to show the treatment people had received. We found a number of gaps on the records with no reason recorded why medicines had not been given. Also, contrary to current guidance, safe procedures for ensuring the correct dose was administered when handling and recording oral anticoagulants (blood thinners) were not in place.

The room used to store medicines was secure, however the medicines awaiting disposal were not stored according to current guidance. Creams and fluid thickeners were not always stored safely. One person had a medicine to thicken fluids next to their bed, which is contrary to a NHS England Patient Safety Alert.

This is a breach of Regulation 12 (2) (g) the proper and safe management of medicines; of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not have appropriate arrangements in place to manage medicines safely. CQC are currently considering its enforcement options in relation to this failure, on the part of the provider to meet the regulations.

During our inspection visit of 17 March and 16 April 2015 we found the service did not have suitable arrangements in place to prevent the spread of healthcare associated infections. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. Following the inspection the provider wrote to us at that time telling us what action they intended to take to ensure they were meeting regulatory requirements.

Inadequate

Is the service safe?

At our visit on 17 March 2015, we became aware of a person who had been diagnosed as having a contagious infection. We also found documentation stating that the patient required to be barrier nursed in order to prevent the potential spread of the infection. We were unable to locate any evidence that barrier nursing was in place. At the time, the service gave assurances that this would be followed up as soon as possible. We conducted a further announced visit on 16 April 2015. The registered manager informed us that barrier nursing was in place. However on inspecting the unit we could not find any evidence that barrier nursing was in place.

During our unannounced visit on 30th July 2015, there was confusion around the management of the person's infection status when two members of staff informed us that the person was no longer being barrier nursed. However, two different members of staff advised us that the person still required barrier nursing. The registered manager told us that their understanding was that barrier nursing had been discontinued. However, they were unable to provide documented evidence to support this. An agency nurse who was working in the house on the morning of our inspection told us they had not been informed that the person was/had been infected meaning that they were unaware of the need for barrier nursing.

On case tracking through the person's care records, we found records between the community infection control team and the service, which clearly indicated that staff were still required to follow universal precautions around infection control for this individual. We spoke to the registered manager about this concern who informed us that they were not aware of the care management advice that had been provided by the community infection control team.

During our visit on 30 July 2015 we were informed by the registered manager that a number of staff had attended recent Infection Control Training a couple of weeks earlier. We were also provided with a copy of the training programme.

On the day of our inspection, the home reported an outbreak of gastrointestinal disturbance the previous day and included symptoms such as nausea, vomiting and diarrhoea. However we could not locate appropriate care plans covering gastro intestinal disturbance for any of the people affected. We found that staff were therefore not provided with clear guidance on how to provide appropriate support in this instance. We looked at a positional change care plan for a person who had experienced these symptoms. The care plan clearly stated that the person needed to be checked and turned every two hours. We found that one person had not received any attention on the day of our visit for a period of three hours and 20 minutes in contradiction of the instructions provided.

We saw a sign on the entry door advising of the outbreak. However, we could not locate a supply of Personal Protective Equipment (aprons, gloves etc.) for visitors to use in the management of the potential reduction of cross infection.

We found that none of the affected people had been referred to their GP for medical assessment with regards to potential dehydration or other health complications that could/may have been a health risk to vulnerable people during the outbreak. Staff told us that people were taking small amounts of fluid, but the amount for each person was unknown and had not been recorded. During our visit we found that relatives of people affected by the outbreak had not been informed by the service.

During our visit we observed three different members of staff who had been supporting people who were unwell then walking around communal areas without changing their aprons. We also saw a member of the kitchen staff walking though the infected area and returning to the kitchen without taking any precautions to prevent the spread of infections. We brought these concerns to the immediate attention of the registered manager.

This was a breach of Regulation 12(2)(h) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, because the service did not have effective systems in place to prevent the spread of healthcare associated infections. CQC has issued a Warning Notice with conditions to be met by 05 February 2016.

During our visit on 17 March and 16 April 2015 we found that staffing arrangements did not protect people from the risks associated with inappropriate unsafe care, because care was not delivered in such a way to meet people's individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the

Inadequate

Is the service safe?

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person-centred care. The provider wrote to us at that time telling us what action they intended to take to ensure they were meeting regulatory requirements.

During the inspection on 30 July and 06 August both staff and people who used the service consistently said that staffing levels were insufficient to meet people's needs. Nursing staff informed us that they struggled to get the medication rounds completed in time, which we observed during our inspection.

A member of staff told us: "Every nurse struggles with medication, because of how complicated the rounds are and take at least two hours. We have to deal with phone calls and deal with visiting professionals. We are all under pressure. Even with current staffing levels of today, that's still not enough to meet peoples' needs, especially for end of life care. I don't think the service has addressed the medication and staffing issues, which has been on-going for some time."

Another member of care staff said: "The nurses are run ragged, they don't get the breaks they need because they are so busy. We have a good team of carers, but we need more, because we are still washing and dressing people at 1 pm. During the morning I spend more time washing and dressing people. People only get one bath a week, if we had more staff they could have two or three. We have one resident who has arranged a shower every other day, (the person) takes a long time in the shower and then it becomes impossible to fit everybody else in. Some people are not even given one bath a week, if we had more staff people could have more regular baths. I know families are not happy. I feel people are safe, but its staffing levels, you are constantly trying to catch up."

Care staff informed us that they also needed more assistance, which we observed through delays in responding to call-bells and lack of staff in the communal areas to observe and support people who were mobilising to ensure they were safe and not at risk to falls. One person who used the service told us that staff had left them for a long period of time without assistance and they rang their son to attend the home to assist them. This person explained their son did not attend but rang the manager to insist somebody responded to his family member's needs immediately.

This was a breach of Regulation 18(1) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, staffing, because there were insufficient numbers of staff to effectively meet the needs of people who used the service. CQC has issued a Warning Notice with conditions to be met by 05 February 2016.

Whilst walking round the building, we observed a bedroom door propped open. The person inside the room was anxious, calling out and attempting to place their legs over the bed rails that were in place. The nurse call bell was placed out of reach. We observed the care the person received over a period of time and had to highlight the lack of response to staff on two occasions to provide assistance. We asked a member of care staff who came to assist why the person was still in bed. They replied "because they (the person) shout at other residents." They also informed us it was easier because of the person's challenging behaviour.

The care plan contained an action plan, which identified how to support this person to spend time out of their room and in the lounge area. The care plan instructed staff to support and encourage the person to spend time in the lounge but to ensure that they were not caused any additional distress by this activity as they (the person) struggled when in the company of others. The care plan instructed staff to start by aiming for short periods of time in the lounge at least every other day.

We found that food and fluid charts for this person were in place but these contained inconsistent entries. Prevention of pressure sore development charts were also in place but not fully completed. There was an entry from 30 July showing personal care given at 4am, 7am with no further entries until 2pm. We also saw that a DoLS assessment tool had been completed, but this was not accurate. The registered manager told us that a DoLS application had previously been made to the supervisory body prior to the date of our inspection but this had not been completed and no formal standard authorisation to deprive this person of their liberty had been granted.

We spoke to the registered manager about these concerns, who agreed to submit a safeguarding referral for this person.

This was a breach of Regulation 13(4)(b)(c) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safeguarding. Care and treatment of people who use services was provided in a manner that was

Inadequate

Is the service safe?

degrading and included acts that intended to control or restrain a person that was disproportionate to the risk of harm posed to them. CQC has issued a Warning Notice with conditions to be met by 05 February 2016.

When we returned on 06 August we saw that this person was out of bed and eating breakfast in the lounge area. A nutritional supplement had also been provided as identified in the care plan. The registered manager confirmed the supervisory body had agreed to prioritise the outstanding DoLS application.

Requires improvement

Is the service effective?

Our findings

During our inspection visit of 17 March 2015 we found the service did not have suitable arrangements in place to ensure staff were suitably qualified to provide End of Life (EoL) Care in respect of necessary qualifications, skills and experience to so safely. This was in breach of Regulation 12(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. The provider wrote to us at that time telling us what action they intended to take to ensure they were meeting regulatory requirements. Following that inspection we were assured by management that training specifically around drug calculation and care of an operating syringe driver would be completed.

During our inspection on 30 July 2015 we were provided with evidence that the service had sourced training around drug calculations. We were also provided with documented evidence that registered nurses competencies had been measured. However, on closer inspection this document was a register of attendance of drug calculations training and did not demonstrate that measurement of specific competencies of registered nurses had been completed

We spoke to one registered nurse who stated that they were not confident in several areas relating to the use of syringe driver equipment that may be used in the delivery of End of Life care. The registered nurse reported that in the absence of more senior staff and in the event of the need to complete one of the above actions, they would either contact the GP, district nurses and at a last resort they would call 999. We could not find any information in the care plans regarding supporting people's end of life wishes with respect to their choices around resuscitation.

We spoke to management about this issue and identified the shortfall of training and competency audits, which gave rise to our concerns regarding the effectiveness, safety and responsiveness of the provision of EoL care that was delivered by the home. In response to these concerns, management told us that they would ensure that there was at least one trained and competent nurse available in the home at any given time. The service was currently arranging training for remaining staff to ensure they were competent to undertake such duties if required.

This was a breach of Regulation 12 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. The service failed to ensure all staff providing EoL care had the necessary qualifications, competence, skills and experience to do so safely. CQC has issued a Warning Notice with conditions to be met by 05 February 2016.

Inadequate

Is the service well-led?

Our findings

During our last inspection on 17 March and 16 April 2015 we found the registered person did not effectively monitor the quality of service provision. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance.

The provider wrote to us at that time stating what action they intended to take to ensure they were meeting regulatory requirements in respect of: the proper and safe management of medicines; infection control management; the provision of suitably qualified staff to provide care; the provision of sufficient staffing levels to meet peoples needs; effectively monitoring the quality of service provision. At the inspection on 30 July and 06 August 2015 we found the service had failed to address the issues identified at the previous inspection.

During our visit on 30 July and 06 August we found the service did not effectively monitor the quality of service provision. The service undertook a range of audits of the service to ensure different aspects of the service were meeting the required standards. However, as a result of the concerns we identified around medication, infection control and end of life care and staffing requirements, it was apparent the service was not effectively assessing and monitoring the quality of service provision.

We found that a meeting had been held with the registered manager and registered nurses on 18 June 2015 following our inspections on 17 March 2015 and 16 April 2015. We saw that internal audits of medication had been undertaken since our last visit. We reviewed the record of the meeting minutes and saw that medication issues were discussed, but it was not clear what action had been taken to resolve the issues identified at that time.

At the inspection on 30 July 2015 we found management had failed to address the concerns we identified at the last visit on 17 March 2015 and 16 April 2015 around medication including guidance to staff on how to safely administer when 'required medicines' (PRN), the correct completion of medication administration records (MAR), the storage of medications awaiting disposal, staff knowledge of the protocols governing the administration of end of life medications and the length of time of the medication rounds. This meant that people were still not protected against the risks associated with the unsafe management of medicines because internal audits were ineffective.

Though the service undertook infection control audits we found that appropriate personal protective equipment had not been provided when required. Quality assurance systems had failed to identify and address such concerns in a timely manner.

The service did not have any systems in place to identify that people were being unsupervised for long periods of time. Residents were left unsupervised in the lounges and dining rooms for prolonged periods. An analysis of staff deployment in relation to people's needs had not been carried out. Staff and relatives raised concerns about insufficient staffing levels. Staff did not respond to nurse assist calls in a timely manner and there was no continuous monitoring of call bell response times as a means of addressing these concerns.

During our last inspection the registered manager informed us that staffing levels would be reviewed in light of the concerns we raised. During this inspection, we found staffing levels remained unchanged and we identified the same concern regarding suitable staffing levels to ensure people's needs were effectively met.

The service did not have a system in place to ensure staff competency was assessed and recorded in respect of the administration of end of life care medicines.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance because the service did not have effective governance and auditing systems in place to monitor their service against Regulations 4 to 20A Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC has issued a Warning Notice with conditions to be met by 05 February 2016.

There was a registered manager in place. 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.

Inadequate

Is the service well-led?

We found that the service had failed to notify CQC about recent medication errors. We spoke to the registered manager about this concern and they told us they had been previously instructed not to report medication errors as allegations of abuse to CQC but they were unable to substantiate where they had received this instruction. This was a breach of Regulation 18 (2) (e) Care Quality Commission (Registration) Regulations 2009 (part 4), which will be considered outside the inspection process in this instance.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were insufficient numbers of staff to effectively meet the needs of people who used the service.

The enforcement action we took:
CQC has issued a Warning Notice with conditions to be met by 05 February 2016.

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not have effective systems in place to prevent the spread of healthcare associated infections.

The enforcement action we took:
CQC has issued a Warning Notice with conditions to be met by 05 February 2016.

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Care and treatment of people who use services was provided in a manner that was degrading and included acts that intended to control or restrain a person that was disproportionate to the risk of harm posed to them.

The enforcement action we took:
CQC has issued a Warning Notice with conditions to be met by 05 February 2016.

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not have effective governance and auditing systems in place to monitor their service against Regulations 4 to 20A Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
CQC has issued a Warning Notice with conditions to be met by 05 February 2016.

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have appropriate arrangements in place to manage medicines safely.

The enforcement action we took:
CQC are currently considering its enforcement options in relation to this failure, on the part of the provider to meet the regulations.