HC-One Limited

The Orchards

Inspection report

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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service. This inspection was unannounced.

The Orchards provides personal and nursing care for up to 72 people. People living in the home may be older or younger people with physical disabilities, dementia or have health conditions that require nursing. Bedrooms are provided over two floors and each bedroom has en suite facilities. There are communal areas consisting of lounges, dining rooms, activity room and courtyard garden for people to use. There are adaptations and equipment available so that the needs of people with reduced mobility can be supported and access all areas of the home.

At our previous routine inspection of 15 and16 October 2013 we found that there had been breaches of legal requirements in respect of managing people's dignity, nutrition and records management. At our responsive inspection of February 2014 we found that people's

Summary of findings

dignity was being maintained however there were other breaches of legal requirements. These were in respect of meeting people's needs, management of medicines, quality monitoring of the service and records management. At this inspection we saw that some improvements had been made but further improvements were needed. Following our inspection we held a meeting on13 August 2014 to discuss our findings and decide on the actions we were going to take. You can see what actions we have told the provider to take at the back of the full version of the report.

There was no registered manager in post at the time of this inspection however the provider had appointed an acting manager. This meant that actions had been taken to someone who would be responsible for the day to day management of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

There had been a lack of consistent management in the home since October 2011 and this meant that people had not always received good quality care and staff were not always provided with support and leadership. There were some audits that monitored the service provided but there was not always adequate analysis and action planning to address identified issues. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the time of our inspection there were 48 people living in the home. We saw that people were not always safe and protected from harm because the service continued to be in breach of Regulation13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to the shortfalls in the safe administration of medicines. Our checks on the amounts of medicines in the home showed that some people had either been given more or less than the prescribed levels of medicines. This meant that their medical conditions were not always treated appropriately and according to the prescriber's instructions. The necessary information to ensure that medicines given disguised in food or drink, on a when required basis and when people were responsible for their own medicines was not in place. As a result of these breaches we have decided to take enforcement action to ensure the future safe administration of medicines.

The provider had taken steps to protect people from abuse and although most people told us they felt safe in the home two people told us they were shouted at by staff. They were unable to give us specific details about this so we brought it to the provider's attention to monitor. Recruitment procedures ensured that checks were undertaken to ensure that staff were suitable to work with vulnerable adults. Staff received training and care records contained the information staff needed to support people safely.

People's rights were not always protected because meetings had not been held to determine that the actions taken were in people's best interests when they were not able to make decisions for themselves. No Deprivation of Liberty Safeguards (DoLS) applications had been made although bed rails were in use and they could restrict people's liberty.

We saw that staff were able to meet people's basic needs but at times staff were not available to support people and there had been a high dependency on agency staff so that people did not always know the staff supporting them. Staff recruitment was underway to address these issues.

People's nutritional and hydration needs were planned for and advice obtained when people were at risk of poor nutrition. People had a diet that was varied, nutritional and presented mashed or pureed where needed so that people were protected from the risks of choking. Improvements could be made to the management of mealtimes.

People's health care needs were met by referral to the appropriate healthcare professionals including doctors, nurses, dieticians and chiropodists

People with capacity were able to choose whether they took part in activities but some people without capacity received inconsistent access to activities.

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?
The service was not safe.

Although people told us that they felt safe we saw that they were not protected because they had not always received their medicines as prescribed and with the appropriate safeguards in place.

There were restrictions in place for some people without the appropriate agreements in place to show that the actions taken were in their best interests.

There were not always sufficient staff on duty with the skills and knowledge to provide safe and consistent care. There was an over reliance on agency staff so that people had not always received continuity of care from staff that they knew.

Inadequate

Is the service effective?
The service was not always effective.

Staff were supported to gain the skills and knowledge needed to carry out their roles but people's needs were not always met effectively.

People's nutritional needs were met and dietician's advice was followed so that people were able to eat safely. People who needed support to eat were given this support but some people had to wait for assistance.

People's healthcare needs were met appropriately. The premises and available equipment meant that people's diverse needs were met.

Requires Improvement

Is the service caring?
The service was caring.

People were positive about the care they received and we saw that staff were kind and showed concerns for people and their relatives.

People's dignity and privacy was respected by staff who knocked on bedroom doors and used people's preferred names to address them.

Good

Is the service responsive?
The service was not always responsive.

We saw that people who were able to make choices about what they did had their social needs met but people who were unable to make choices were not always given the support necessary to meet their needs.

Some relatives did not feel adequately consulted about people's care and were concerned about what would happen if they did not visit the home regularly.

Requires Improvement

Summary of findings

People were supported to maintain relationships important to them. People's views were listened to and actions taken to address concerns raised.

Is the service well-led?

Requires Improvement

The service was not well-led.

Staff had not been provided with support that ensured a good quality of care was provided to people because registered managers had not stayed in post long enough to provide stability and leadership.

Senior managers acknowledged that several aspects of the service needed to be improved. There was a lack of analysis of trends and patterns in audits to make sure that appropriate actions were taken to improve the service.

The Orchards

Detailed findings

Background to this inspection

This inspection was carried out by an inspection team that consisted of three inspectors, one of whom was a pharmacist inspector, and an Expert by Experience who had experience of services providing care to older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type service.

Our last routine visit to this service was carried out on15 and 16 October 2013 when we found that there were shortfalls in how the service maintained people's dignity, how their nutritional needs were met and the management of records. On 18 and 19 February 2014 we carried out a responsive inspection because we had received concerns that standards were not being met in the home. We found shortfalls in how people's care and welfare and medication needs were being met. Staffing levels were not sufficient to meet people's needs and there needed to be improvements records management and the assessment and monitoring of the quality of the service. We carried out a further responsive inspection on 24 June 2014 because we had received concerns about inadequate staffing levels that resulted in people's needs not being met. However, we found that improvements had been made to the staffing levels at the time of that visit and people's needs were being met.

We carried out this routine inspection on 31 July 2014 and 4 August 2014 and spoke with 14 people who used the service, ten relatives, seven staff and senior managers supporting the home. We looked around the home to assess the premises and facilities available to people. We observed care and support provided to people and looked at the care records of three people, the recruitment and training records of three staff and a range of records relating to the management of the home.

Before the inspection we reviewed information we held about the home. The provider sent us a provider information return that gave us information about the home and we looked at notifications the home had sent us. Prior to our inspection we spoke to two people from the local authority and the clinical commissioning group.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

A pharmacist inspector had visited the service on the 19 February 2014 and found that the management of medicines was not safe and placed people's health and wellbeing at risk. Our inspection on the 31 July 2014 included a review of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found that the service continued to be in breach of Regulation 13.

We looked in detail at 12 medicine administration records to check whether people were receiving their medicines as prescribed by their doctor. We found that the service was not able to demonstrate that people were receiving their medicines as prescribed. We found evidence that ten people had not received the correct dose of their medicines. In some instances more tablets/doses remained than expected and in others some medicines were missing and the probability that these people had received more than the prescribed dose was evident. This meant that people's medical conditions were not always being treated appropriately by the intervention of medicines prescribed for them.

We found that where people needed to have their medicines administered by disguising them in food or drink the service had not ensured that the necessary procedures were in place to administer the medicines safely and in people's best interests.

We looked through the records for people who had been prescribed medicines on a 'when required' basis to see if there was enough information to inform the nursing staff on how these medicines should be administered. In some records that there was no information on how to administer these medicines. Where information was available it was not sufficient to show the nursing staff how to safely administer these medicines. The lack of information about how medicines should be managed may result in people using the service not getting their medicines when they need them.

We found that the procedures for people wishing to administer their own medicines were not in place. In one particular case and as a consequence of the lack of instruction, the service was unable to demonstrate that the medicine was being administered as prescribed and that people who wished to self-administer were doing so safely.

We looked at the disposal records for medicines that were no longer required by the service. We found that when people refused medicines the nursing staff disposed of these unwanted medicines and made a record on the administration record using a defined abbreviation. We cross referenced these abbreviations against the disposal record to confirm that these medicines had been disposed of but the records were not able to show that the refused medicines had been disposed of accordingly. This meant that the service was unable to account for these medicines and prove that the medicines had not been inappropriately used.

The service had introduced a system to record where various types of pain relieving patches were being applied to the body. We looked at these records and found that staff were not always making a record of the application. We also found that when a record of the application had been made the location of the patches was not always recorded. The service was therefore unable to demonstrate that the patches were being applied safely in accordance with the manufacturer's instructions. People were therefore at risk of developing local irritation because the patches were only placed on one part of the body.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All the relatives we spoke with were happy with the service provided but did not feel assured that their family members care would be appropriately maintained if they did not visit. All the staff spoken with told us and training records confirmed that they had received training in safeguarding people. Although the staff we spoke with were knowledgeable about types of abuse and the actions they would take if they suspected any abuse comments made by some people suggested that training and knowledge was not always reflected in staff practices. For example, one person told us, "I feel safe and secure." however, two people said that they were sometimes shouted at. One of these people told us, "They don't seem enough (staff) and if you say anything they tell you to shut up so I don't say anything." This showed that some people felt unsafe and unable to express their opinions. We brought these comments to the attention of the provider's representatives so that they could monitor this.

The records of three staff showed and all the staff spoken with confirmed that the recruitment process included completion of an application form, formal interview, two

Is the service safe?

references obtained from previous employers and a disclosure and barring check (DBS). This showed staff were been checked for their suitability to work with vulnerable adults and received the information they needed to help keep people safe from abuse.

Managers in the home at the time of our inspection told us that there was no one who was subject to any restrictions on their liberty and no applications had been made under the Deprivation of Liberty Safeguards (DoLS). One staff member spoken with told us that they had not received training in the Mental Capacity Act 2005 and were not sure what it meant. We saw that mental capacity assessments were not always in place and best interest meetings were not held to ensure that where people lacked capacity decisions made were in their best interests. For example, records showed that the use of bed rails had been explained to one person; but the person did not have capacity to make a decision about bedrails and agree to the actions taken. There was no evidence in the care records that a best interest meeting had been held to decide that the use of bedrails or a specialist chair, which could restrict the person's movements had been held to ensure that the actions were taken in their best interest.

The care records we looked at contained some risk management plans. For example, for the risk of choking, malnutrition, falls and skin damage. However, we saw that some risk assessments were missing for example for the use of specialist chairs. This could lead to people not having their needs met safely because there was no management plan in place to make sure that people were not left in the chairs for long periods of time therefore restricting their movements.

Environment risk assessments and management plans were in place to manage issues such as the actions taken to prevent a fire and the actions that staff were to take in the event of a fire. This showed that people were protected from risks that could be anticipated. Staff spoken with were able to tell us of the actions they would take in the event of an accident so that people received the appropriate support to get treatment and reassurance as needed.

We were told by manager's that staffing levels were based on people's assessed dependency levels. At the time of our inspection the numbers of staff on duty reflected the staffing rota. We observed that people had to wait to have their needs met. For example, at lunchtime we saw that despite some support from relatives there was a delay in some people receiving the support they needed to eat their meals. One person told us, "There is not enough staff. Lately there have been new ones. Staff are pushed for time. When called staff usually come quickly but sometimes we have to wait." Staff we spoke with told us the staffing levels were not sufficient to meet people's needs when agency staff were part of the staffing complement because they did not know people's needs. This view was reflected by two visiting healthcare professionals. One member of staff told us, "There is enough staff but not when three out of six carers are agency. There should be more, and then we would be able to have more time to spend with people. Very good staff are leaving". This showed that some people had to wait for assistance because the staff numbers, skills and experiences were not sufficient to meet people's needs particularly at times of peak activity.

The premises were suitable to meet the needs of people and were well maintained. Equipment to support people such as hoists, passenger lift, nursing beds, bed rails and hot water temperature restrictors was regularly serviced and available so that people's needs were met safely. Equipment available was suitable to meet people's needs. For example, there were a variety of hoists and slings that could be used for people of different sizes and abilities. Systems were in place to ensure that only authorised people gained access to the premises. This meant that people were kept safe.

Appropriate infection control policies and procedures were in place and staff practices reflected that. We saw that staff wore gloves and aprons when assisting people. A member of staff explained the process for handling and cleaning soiled clothing so that cross infections were minimised. There were systems in the kitchen that ensured that there was safe food handling and preparation. Temperatures of cooked foods, fridge, freezer and dish washer were checked to ensure that risks of food poisoning were minimised. Audits of infection control practices were undertaken and the last audit had identified actions that needed to be taken. Although there was no action plan in place to identify how improvements were to be achieved we saw that the premises were clean.

Requires Improvement

Is the service effective?

Our findings

People were supported with care and involved in making decisions about their appearance and the equipment they used People told us they thought that the staff were good and supported them to meet their needs.

One person told us, "Staff will walk me up the corridor soon. They do it every day." The person needed to undertake daily exercise to improve their mobility. Another person said, "I think staff know what they're doing. They know what I like and want." A third person told us, "Staff know I like blue and they usually put blue clothes on."

Staff had the skills and knowledge to support people. Staff told us and records confirmed that they had received the required training to ensure that they could support people in line with current good practice guidelines. All the staff we spoke with were knowledgeable about people's needs. They told us and we saw that care records included information about people's likes and dislikes and preferences. However, the support that some people received was not effective. We saw one person whose nails had not been cut and a thumb nail had broken but was still attached. The nails of another person were very dirty and they were eating their meal with their hands. This showed that care was not always provided appropriately and according to individual needs.

All staff spoken with told us that during their induction training they received training such as how to move people safely and that they initially spent some time working with experienced staff. This enabled them to get to know people's needs so that they could provide effective and appropriate care. The managers in the home told us and records showed that there had been a shortfall in the level of supervision staff received. A plan had been set up to ensure that all staff received the required level of supervision but it had only just been implemented so we were unable to assess its effectiveness. Records showed and staff confirmed that they received regular training updates that ensured their knowledge and skills were maintained and developed.

People's nutritional needs were met and choices were available. Two people told us, "I get enough food" and "There's lots of food, very good food. I know what I can choose from the menu (they needed a specific diet)." One person said that they didn't like what was on the menu but was able to choose an alternative. We saw plans that recorded the needs of people at risk of malnutrition. This included alerting kitchen staff to people's needs so that they could take steps to increase their calorie intake. The spacing and timing of meals ensured that people received food and drinks at regular times throughout the day. People who had problems with swallowing had been referred to the dietician and their advice was usually followed. We saw that everyone was weighed on a regular basis so that their weight and health could be closely monitored. People identified as at risk of poor nutrition were weighed more regularly as identified in their care plans. However, the support that some people received could be improved. One person had been given a thickened cold drink, as identified in their records, but a cup of tea had been given without thickener added. The individual was able to drink independently and this could have put the person at risk of choking.

We saw that some people enjoyed mealtimes with good interactions with staff and pleasant background music playing. However, others had to wait to be assisted to eat their meals, and we saw staff take food to people's bedrooms because they did not know that the individuals were waiting for their food in the dining room. This meant that people had a variable experience at mealtimes.

Four people we asked told us they received support to access healthcare services. One person told us, "If I ask for the doctor they will visit. I see the optician and chiropodist when needed." One person told us that they were waiting to see a doctor and later in the day we saw the doctor visited them. Records confirmed people's health care needs were met through the involvement of a range of health care professionals both within the community and at the home. All the relatives we spoke with told us that they were kept informed about their relative's health and they were confident their needs were met. This meant that people were supported to maintain good health and had access to health care services when needed.

We saw that the premises were suitable to meet people's needs. All bedrooms were for single occupancy and all had en suite and washroom facilities and a nurse call system. There was a courtyard garden that was accessible to people and visitors who wished to relax there. Lounges and dining areas provided sufficient space for people to relax in

Requires Improvement

Is the service effective?

and eat their meals. There were adapted baths and showers so that people had a choice of bathing facilities. Passenger lifts were available to enable people and their visitors to have access to both floors.

Good

Is the service caring?

Our findings

The five people and one relative we asked about staff made positive comments about the staff team. One person told us, “Yes, staff are nice.” Another person said, “The staff are very good. Yes caring.” A relative told us, “Staff are ever so good. They meet all mum's needs.”

All our observations showed that the interactions, although usually task orientated, were warm and friendly. For example, as one carer was walking past a bedroom they asked the person who was sitting there how they had been overnight. We saw an ancillary worker checking the nurse call panel to see who was calling for assistance. We asked if they usually checked the panel. They told us, “It’s all our responsibility to ensure that they are answered quickly. It could be that they have dropped something and I can deal with that.” This showed that all staff felt accountable for meeting people’s needs.

During our visit we saw staff ask a person who was leaning to one side in their bed if they wanted to be made more comfortable. Staff explained what they were doing during the procedure and made the person comfortable showing that staff were caring towards people.

We saw that the majority of people’s privacy and dignity was respected and promoted. However, on the first day of our inspection we saw that one person was sat in the lounge with clothing that was too big for them and that had fallen down when they had been supported to sit down. On the second day their dignity was well managed. This showed that sometimes dignity could be better managed for this person.

One person we asked told us, “Staff ask you if there is anything you want and need. They knock on the door before coming in and close the door and curtains when providing personal care. All the staff we spoke with were able to tell us how they ensured that they promoted people’s dignity and privacy. We saw that there was information about dignity champions in the home. Dignity champions are staff who have additional responsibility for ensuring that people’s dignity is maintained. We saw that everyone had their own en suite facilities and this supported people’s dignity to be promoted.

There were ‘do not resuscitate’ agreements in place for some people so that staff knew what actions people wanted to be taken in the event of a heart attack or deterioration in their health condition. People had care plans that detailed the care people wanted to receive when they were approaching the end of their lives and the actions to be taken when they had passed away. A member of staff told us that it was important to know whether people wanted to be admitted to hospital or not and what their end of life requirements were in respect of their individual and cultural needs and so that pain relief could be appropriately managed. This showed that people were consulted about what they wanted to happen and how their passing could be best managed.

Requires Improvement

Is the service responsive?

Our findings

Most people were involved in making decisions about their care. For example, one person told us, "I like to stay in my bedroom." We saw that they were supported to receive their personal care needs, eat their meals and watch television in their bedroom. Most relatives spoken with told us that they had been asked about their relative's likes and dislikes and kept informed about their relative's welfare. One relative told us that they were involved in an annual review of their relative's needs and they had seen their care plans. Another relative acknowledged that the home tried to meet their relative's needs but felt they were not adequately consulted before changing the way support was provided. Two relatives told us that they had not been consulted. This showed that some people did not feel adequately consulted about their relatives care.

Records of meetings held for people and their relatives showed that they had opportunities to discuss issues and make suggestions. We saw from these records that people were kept informed about activities and improvements in the home such as the installation of a new nurse call system and improvements to the garden. We saw that there had been a survey completed to get the views of people about the service and the actions to be taken as a result. For example, local trips out and the formation of a relative's committee.

People were able to choose whether they got involved in hobbies and interests or not. Some activities were organised for people. This meant that people who had capacity were able to choose what they were able to do to keep themselves occupied. We saw that one person who did not have capacity to make decisions and who displayed behaviours that challenged others was left for long periods of time alone in the lounge or their bedroom. One staff we spoke with said they did not know why the person shouted out but when they shouted they would go and talk to them. We did not see this happen while we were in the home on the first day of our inspection. Their care records indicated that they enjoyed the company of other people and chatting to the person reduced their anxiety and loneliness. On the second day of our inspection we saw that the person sat in a lounge with other people and was not heard to be shouting out. This showed that this person received an inconsistent service that could affect their wellbeing.

People were supported to maintain and develop relationships. Family members told us they felt welcomed at the home. People were encouraged to go out with family members and friends and to keep in touch by phone.

We saw that staff responded promptly when people used the nurse call buzzers. Since our last inspection senior staff had been provided with pagers so that they were able to identify if a buzzer was not responded to and take the appropriate action. This meant that people were not waiting for long periods for call bells to be answered.

The home had a complaints procedure in place. We saw that some relatives had made complaints and they had been appropriately actioned. A member of staff told us that if someone complained to them they would try to address the issue or refer it to the manager. They told us, "Relatives have complained about staffing levels and managers have put more staff on." One relative told us, "There are some very good staff. Managers say they will do things but they never fulfil. There are meetings to attend." This showed that systems were in place to get people's views but people did not always feel that actions were taken.

We saw that people were supported so that they continued to receive appropriate care from other services. For example, staff worked with health and social care professionals to meet people's needs. During our inspection we saw that a doctor had been called to see someone who was unwell. They told us that they were contacted appropriately when people were unwell. Staff told us that when people went into hospital they were escorted by staff until relatives were able to attend. Information regarding their needs and medications was passed onto hospital staff to ensure that they were aware of their needs.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager in post at the time of our inspection. We found that there had been a number of changes of manager at the home and this had led to a number of complaints regarding staffing levels and the level of care provided in the home since our last scheduled inspection. One staff member told us, "The management has been up and down. Several changes of manager. The current managers do listen." Another staff member told us that the lack of continuity of senior staff meant they felt they had to raise concerns only to colleagues and then they had to sort things out between themselves. There was a team of managers that were supporting the home to improve at the time of this inspection. We were told that an individual had been identified to become the registered manager but they had not yet submitted an application to register with us. It was acknowledged by managers that at the time of our inspection some improvements were needed. These improvements included management of medicines, care planning, care delivery and supervisions for staff. This showed that the home was not currently well-led but actions were being taken to improve the situation.

The service had auditing and monitoring procedures in place. We saw that there were bimonthly visits by a senior manager in the organisation where audits were carried out and action plans were put in place. As well as this we saw that specific audits were undertaken in relation to areas such as medication, infection control and health and safety. We found that despite audits in respect of medication sufficient improvements had not been made in the management of medicines to make sure that people received their medicines as required. There were records of safeguarding alerts raised, complaints, and surveys but there was a lack of analysis and action plans available to show that issues raised had been addressed or that trends and patterns were identified to advise follow up action.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that people using the service and staff were supportive of the current deputy manager who was in the process of getting to know people and the improvements needed in the home. People and relatives spoken with told us that they had the opportunity to express their views about their care and the service. There were meetings arranged where staff and people could make suggestions for ways to improve the service. For example, staff had raised concerns about the number of falls one person was having and they were moved to a bedroom nearer the nurse's stations so that they could be monitored closely. Relatives had commented that changes made were not working and the provider had listened and taken the appropriate actions. Surveys were also carried out to get people's views so that the service could be improved generally and for individual people. This meant that people had opportunities to comment about the service provided.

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers : People who used services were not protected from the risks of inappropriate or unsafe care and treatment because there were not adequate systems to assess and monitor the quality of the services provided. Regulation 10 (1) (a).

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	People who used services were not protected against the risks associated with the unsafe use and management of medicines by means of the making of appropriate arrangements for the recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. Regulation 13

The enforcement action we took:
Warning notice