Care Quality Commission

Watford House Residential Home Ltd

Watford House Residential Home

Inspection report

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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 caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 4 November 2015 and was unannounced. Watford House is registered to provide accommodation and personal care for up to 43 people. Some of whom were living with dementia. At the time of this inspection 36 people used the service. The last inspection was completed in March 2014 and was compliant with the Regulations we looked at. These included Regulation 9 care and welfare of people, Regulation 14 nutritional requirements, Regulation 12 infection control, Regulation 18 staffing and Regulation 17 records.

Since the last inspection there had been a change in the management arrangements of the service in that the registered manager had resigned the position. A person had been recruited for the manager's position but has not

Summary of findings

been registered with us. They told us an application to register would be submitted shortly. 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.

Risks to people's health and wellbeing were not consistently identified, managed and reviewed and people did not always receive their planned care. People were not always kept safe and their welfare and wellbeing was not consistently promoted because risk assessment and care plans were not consistently followed.

Medication systems, administration and storage were unsafe. People were at risk of not receiving their prescribed medication when they needed it or in the correct way.

Some staff were unsure of the actions they needed to take if they had concerns regarding people's safety. Incidents were not identified as potential abuse; they were not reported or investigated.

Staff did not receive the required training or supervision they needed to support people with their care needs. Infection control was compromised by staff working practices. Some equipment was unsuitable and incorrectly used and areas within the environment were unhygienic which posed a risk of harm for people.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLs) and to report on what we find. There were restrictions of movement in place as people could not access all areas within the home with ease.

People had access to healthcare professionals but did not always receive medical support and interventions in a timely way to ensure their health and well-being was upheld.

People's care was not personalised and did not reflect their individual needs and preferences. Recreational and leisure activities were arranged throughout the week. Some people were given the opportunity to participate in the group activities if they wished to do so. However most people spent long periods of time with little or no stimulation. People were not treated with the dignity and respect.

The provider did not have effective systems in place to assess, monitor and improve the quality of care. Poor care was not being identified and rectified by the provider.

The provider did not inform us of reportable incidents that occurred at the service. This meant we were unaware of incidents, for example injuries and safeguarding concerns that had occurred within the home.

People were aware of the complaints procedure and knew how and to whom they could raise their concerns. Staffing levels were sufficient to provide basic care and support to people.

The provider had a recruitment process in place. Staff were only employed after all essential pre-employment safety checks had been satisfactorily completed.

We found several breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of The Care Quality Commission (Registration) Regulations 2009.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be

Summary of findings

conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can see what action we told the provider to take at the back of the full version of the report.

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. Risks to people's health and wellbeing were not consistently identified, managed and reviewed. People's safety and welfare was not always promoted. Incidents of abuse had not always been recognised or reported. People were at risk of receiving inappropriate and unsafe care. Medication management and infection control procedures were poor.	**Inadequate**
Is the service effective? The service was not effective. There were gaps in the staff's knowledge and skills because suitable training had not been provided. This meant people were at risk of receiving unsuitable care. The principles of the MCA and DoLS were followed to ensure that people's rights were respected. However some decisions were being made without due consideration to the individual needs of people. Some people could not be assured they were eating and drinking sufficient amounts to maintain their health and wellbeing.	**Requires improvement**
Is the service caring? The service was not consistently caring. People's privacy and dignity was not upheld. Staff we spoke with were knowledgeable about the individual needs of the people they cared for. However people's personal preferences were not always considered.	**Requires improvement**
Is the service responsive? The service was not always responsive. People did not receive the care and support they needed in an individual or responsive way. Changes to care and support needs were not reviewed in a timely manner. Social and leisure activities were available to support some people (but not all) with their recreational and social needs. Complaints and concerns were dealt with through the complaints procedure.	**Requires improvement**
Is the service well-led? The service was not well led. The manager in post had been with the service for only a short while; they were not registered with us to manage the home. The application to register with us had not been submitted. Effective systems were not in place to assess, monitor and improve the quality of care. The provider did not inform us of reportable incidents that occurred at the service and poor care was not being identified and rectified. Care records relating to people's care and support needs were not always accurate or reliable.	**Inadequate**

Care Quality Commission

Watford House Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, 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 4 November 2015 and was unannounced. The inspection team consisted of two inspectors.

We looked at the information we held about the service. This included notifications the home had sent us. A notification is information about important events which the provider is required to send us by law.

We spoke with the majority of the 36 people who used the service; some people were able to tell us their experience of life at the home. Some people declined or were unable to, so we spent time in the lounge areas and observed the interactions between people.

We spoke with the provider, the manager, four care staff, four visitors and one health care professional. We looked at six people's care records, staff rosters, staff training records, two staff recruitment files and the quality monitoring audits. We did this to gain people's views about the care and to check that standards of care were being met.

We also gathered information about the service provided from other sources. We contacted the commissioners of the service; commissioners are people who fund placements and packages of care and have responsibility to monitor the quality of service provided. We contacted Healthwatch Stafford; Healthwatch helps adults, young people and children speak up about health and social care services in Stafford.

Inadequate

Is the service safe?

Our findings

The risks of harm to people who used the service were not consistently managed, reviewed or followed to promote their safety. For example one person had been identified as being at risk of choking; the action to reduce the risk had been recorded in the assessment. We saw that staff did not consistently follow the guidance to ensure the safety of this person as they offered a different diet to that recorded in the assessment. The person was at risk of harm because the service did not identify the risks to this person's complex needs with their eating and drinking needs.

Another person required the use of specialist equipment and regular staff support to maintain their health and well-being. This person was unable to tell us about the care and support that was provided, but there were occasions when they looked comfortable and at other times quite distressed. Staff told us this person stayed in bed for the majority of the time. We visited the person several times, on occasions they were comfortable and asleep. At other times they looked anxious, restless and uncomfortable. We saw staff attended to the person during the day to offer refreshments and support with pressure relief. Staff offered differing accounts of the care and support provided to this person. We saw inconsistent recordings in the monitoring forms, for example the repositioning charts, and the records did not correspond with the information offered to us by the staff. This person was at risk of harm due to inconsistent and unreliable care.

Staff told us a person had a pressure ulcer that was being treated by the district nurses. Staff told us that between the visits from the district nurses they had been instructed to change the dressings when it was required. Staff confirmed that they had changed the dressing; they told us they had not received training to do this but had been shown by other care staff. We asked to see the care plan for pressure area care for this person. The senior care staff told us there was no written plan. We saw that the person had a pressure relieving mattress on their bed to support them with reducing the risk of further skin damage. We asked staff if they knew how the pressure relieving mattress should be used. They were unable to tell us if the equipment was set correctly for the individual needs of the person. The person was at risk of harm due to the lack of staff knowledge in providing pressure area care.

We saw a person sat on a pressure relieving cushion; it was deflated and ripped so was not safe or effective for this person. Staff told us this person sat on the cushion to reduce the risk of them developing sore skin. This meant this person was at risk of harm due to receiving unsafe and inconsistent care and the equipment not being maintained or monitored.

We looked at the way the provider managed medicines. Medicines were stored in locked cupboards and trolleys in various areas around the home. Senior staff administered the medicines to people at certain times during the day. We found that some medication was missing and unaccounted for, staff were unable to offer an explanation for this. We saw that some medicines had been removed from their original packaging and placed within other boxes. This meant there were more tablets in the packet than had been prescribed, there was a risk with this practice as errors in transferring from packet to packet could be made and no medicines should be handled in this way. The service did not follow current and relevant professional guidance about the management and review of medicines and people were at risk of not receiving their medicines as prescribed.

Staff told us some people were at risk of developing sore skin due to frailty or immobility and had been prescribed creams, lotions and ointments. Staff told us they applied these at the time of providing personal care to people. They did not sign any record to indicate they have completed this task. Some people had been prescribed several different creams and ointments that were to be applied to various parts of the body. Staff were unsure which cream they were to use on which part of the person's body when we asked them about the treatment for one particular person. People were at risk of receiving external medications that were inconsistent with the prescribing instructions.

Some people required medication that could be given on an 'as required' basis. Staff confirmed there were no protocols or specific guidance (except for a particular analgesic) for staff as to when, how often or why the medication could be given. People were at risk of not receiving their prescribed medication when they needed it.

Some medicines must be stored in a refrigerator because at room temperature they break down or 'go off'. The temperature of the fridge should be recorded on a regular basis and maintained usually between 2 and 8 degrees

Is the service safe?

Celsius. Staff told us the fridge should be monitored daily and a record of the temperature made. On the record we saw many gaps where the temperature had not been recorded, and since August 2015 the maximum temperature recorded was in excess of the recommended levels. No action had been taken by the manager or provider. The effectiveness of the medicines stored in the fridge could not be guaranteed. We spoke with the manager and provider about our concerns regarding the storage of medication and requested they took action to ensure the medication was safe to use.

Infection risks had not been identified by the staff. During our inspection we saw that refuse bins located in toileting and communal areas were broken or unsuitable. One of the bins had a broken foot pedal and the others contained no lid. This meant there was a risk that people would touch the bins with their hands to open them, increasing the potential spread of infection or people could easily access the contents of the bin that contained no lid.

Some people required staff to support them with their personal care. There were no hand wash facilities for staff to use in the bedrooms. For the effective control of the spread of infections suitable hand wash facilities should be provided at the point of the delivery of care. We saw care staff walked around areas of the building wearing disposable gloves prior to and after supporting people with their personal care. This posed an infection control risk as staff were not using or disposing of the gloves in the correct way.

Some people required a commode in their bedrooms for use during the night. Staff told us a sink in the sluice room was used to wash the commodes. We saw the sink in the sluice room was very soiled and in need of a thorough clean. No chemicals, cleaning equipment, hand wash or protective equipment was available in this room. This posed an infection control risk. We spoke with the provider who immediately took action to ensure the necessary equipment was readily available. The provider also confirmed that an automatic disinfector sluice machine would be purchased and installed to ensure staff were protected and cross infection risks were reduced.

The concerns above showed that there was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not always receive safe care and treatment.

Two members of staff were unsure of where they would report any concerns regarding the safety of people. One staff member 'thought' they would speak with the manager and another told us that 'maybe' they would report their concerns to us (CQC). They were unsure when they last received training in safeguarding people. We saw a person sustained an injury when they had been left in a compromising position by staff, the event had been reported to senior staff but no action had been taken by the manager or provider. No action had been taken by any staff member to ensure the risk of this happening again was reduced. This safeguarding incident had not been reported in accordance with local safeguarding procedures. This meant that appropriate action was not taken to protect the person's safety and welfare.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always safeguarded from abuse and improper treatment.

Staff told us there were enough staff to provide the care and support to people. One person went on to say: "Until someone goes off sick, like today it leaves us short. When fully staffed we cope okay, we have been short recently as people are on holidays and off sick". A relative told us: "The care staff are very approachable and there always seems to be someone around". We saw that staff were busy attending to the care needs of people. Staff did not have time to sit with people and provide personalised care but focused on the task they were required to do.

Staff told us and records confirmed that the provider had an effective recruitment procedure in place. This meant staff that were employed had been subject to checks to confirm they were suitable to work at the home.

Requires improvement

Is the service effective?

Our findings

Some staff told us they had received some training. One care staff told us: "I had medication training last, and I am doing NVQ level four so did dementia recently". Other staff said: "No I have not had any recent training". We saw two staff members providing personal care and pressure area care to one person. They told us the actions they took to reduce the risk of the person's skin and pressure areas deteriorating. For example repositioning and applying creams. Neither staff were sure that the actions they took were correct. Both staff confirmed they had not received training in pressure area care but had been shown by other carers. No care plan had been completed to support and guide staff with providing effective pressure area care.

Some people needed help and support with moving around from area to area. We saw staff used an unsafe method of supporting a person to move out of a chair to go to another area. The person was unable and found it difficult to stand unaided and so held on to staff. No equipment was used to provide support in a safe way. Staff told us: "The person can't hold on but we have nothing else to support them with but we can't lift them. Sometimes it doesn't feel safe, but that was okay today. I think the person might be being reassessed". We looked at the person's moving and handling assessment and care plan. This was unclear and had conflicting information in regard to the person's mobility, the number of staff required to support them and the equipment to be used. This person did not receive care that ensured their welfare and safety. Two staff members told us they had not recently received training in moving and handling. This meant that staff were not appropriately trained to support people with their care needs.

Staff told us they had received supervision with a manager, 'about two to three months ago I think'. Other staff told us they had not had supervision for a 'long while'. We saw records that logged a member of staff had their last supervision session in April 2015. Supervision is a way of supporting staff to do their job well to improve outcomes for people who use services. The manager told us they were arranging for staff to receive an appraisal of their work performance but this was in the planning stage. This meant the staff's work and professional development was not monitored.

Some people who used the service were living with dementia and at times found it difficult to make informed decisions about their care and treatment. The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) set out the requirements that ensure where applicable, decisions were made in people's best interests when they were unable to do this for themselves. Assessments had been completed to establish a person's decision making abilities and decisions were being made by the manager and staff.

We saw the previous manager had completed DoLS referrals for everyone who used the service due to the doors to the exits and between the two units being locked. The manager told us that authorisation to lawfully restrict the liberty of three people had been made; we saw these authorisations were in the care records. For other people no records or care plans were available to show how the manager or provider was providing care in the least restrictive way. We saw there were restrictions of movement in place as people could not access all areas within the home with ease. This course of action resulted in people's freedom being restricted.

People told us they enjoyed the food and had enough to eat and drink each day. One person told us: "The food is good and I've had some toast it's very nice". People were offered a choice of meals and drinks. We observed the lunchtime meal period. We saw the meal was served by the care staff from an unheated trolley. Some people waited for a period of time before they were served their meal; staff did not check the temperature of the food before they offered it to people. This meant meals presented to some people was not at an appropriate temperature and resulted in the food being cold and some people not eating their meal. We did not see that people were offered an alternative or anything else to eat.

Some people needed support and help with their meal. Staff were available to support them but they were interrupted as and when other people required support. This interruption meant that people lost interest in eating and therefore did not finish their meal. Some people were asked if they wanted anything else but for other people the meal was taken away without staff ensuring they had had sufficient.

People considered to be nutritionally at risk were provided with food supplements to support them with adequate daily nutrition. Some people had food and fluid charts to

Is the service effective?

monitor their daily intake. We saw not all of the charts had been sufficiently completed to provide an accurate account of a person's daily diet or fluid intake. The manager was in the process of introducing new food and fluid charts so that an accurate account of people's nutritional intake was monitored when this was deemed necessary.

We saw some people had visits from their doctor and the district nurses when this was needed. Staff told us and we saw assessments where people had been identified as being at risk of choking; staff confirmed that a referral had not been made to a dietician or speech and language therapist to provide guidance to reduce the risk to them. We spoke with a visiting community health worker they told us they made regular visits to the home to provide healthcare support to people. For example flu injections and taking blood for testing. They told us the staff were helpful and accommodating when they visited.

Requires improvement

Is the service caring?

Our findings

We saw on occasions people's dignity was compromised. One person waited for over an hour when they needed staff to support them with personal care. We saw some people looked unkempt and uncared for. People wore soiled clothing and foot wear. People who were dependent on staff to help them with their personal hygiene had not received nail or oral care. We saw a person who looked very dishevelled, their care plan stated 'likes to look nice and tidy'. People were not always supported in relation to their personal preferences or in a considerate and compassionate manner.

The privacy of people who lived in shared bedrooms was not always taken into consideration; there were no curtains or screenings between the beds to offer people some degree of privacy. Staff told us that one person used a commode in the bedroom for toileting purposes during the night. This meant their dignity would be compromised as they would be in full view of the other person. There were no vacant/engaged signs on communal bathroom and toilet doors to indicate that the facilities were free to use. People's privacy may be compromised when using the facilities due to the lack of suitable signs.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not treated with dignity and respect.

Staff knew people well and spoke about people in a caring manner. Staff were familiar with people's care and support needs, their likes and dislikes but sometimes made assumptions regarding people's choices and options. People were not always offered the opportunity to choose and make decisions for themselves. We saw some staff interactions that did not support people's wishes and choices, for example we heard one person being continually told to sit down by a member of staff when they attempted to move. There was no attempt to support the person or to find out what they wished to do or go.

People told us they were comfortable and happy. One person who used the service told us: "I like sitting here next to the heater; I have the best seat, that's why the staff put me here". Another person said: "There is always someone to come around and smile at you". We saw some staff consulted with some people in relation to making decisions and choices. For example, what they would like to do, where they wished to sit and what they would like to eat and drink.

Relatives and visitors told us they could visit at any time, there were no visiting restrictions. They told us they were satisfied with the care and support provided to the relatives. One relative said: "I am very happy with the care provided to my mum I wouldn't want her to go anywhere else". We saw that staff had developed good relationships with visitors.

Requires improvement

Is the service responsive?

Our findings

Some people stayed in the lounge area for most of the day in one of the units. The television was on, but people were not interested in watching the morning programmes. People were unable to talk with us about their life at the home; they said they were 'alright' when we asked after their welfare. Some people were disengaged, others were asleep and others just looked around. No stimulation was offered and there was very little interaction between people and staff.

Most people who used the service were living with some degree of dementia and relied on staff to help and support them with day to day living. Some staff were knowledgeable in regard to people's likes, dislikes and preferences; however others were not so informed about people's needs. People's personal and social history was recorded in the care plan files which gave staff information about people's lives. A relative told us: "I was involved with a care review when mom moved in July I felt I was listened too". The plans provided limited information about the care required and people's preferences. Care and support plans were not person centred and there was no indication that people had been involved in their care planning.

Relatives told us: "The activities here are second to none. With lots of stuff and entertainment always going on". The home employed an activities coordinator who arranged and facilitated leisure and recreational activities throughout the week. An activities room was available and people were encouraged to join in with the group sessions. We observed a very lively session with a small group of people. They participated and joined in remembering proverbs and old sayings. People were encouraged to make their own drinks during the coffee break. Some people preferred not to join in and said: "I like staying in my room I like the peace and quiet". Their preference was respected.

Visitors and staff told us they would report any concerns or complaints they had to the provider or manager. One relative told us: "I have never had anything to complain about but I would go to the manager if needed". The manager told us of a recent complaint that had been investigated by the previous manager and that it had concluded with a satisfactory solution. The complaint procedure was displayed around the home.

Inadequate

Is the service well-led?

Our findings

The previous manager and the provider had not raised safeguarding referrals with the local authority when there had been incidents of suspected abuse. Investigations were not carried out to reduce the risks to people and lessons were not being learned to ensure people were protected from further harm.

We saw 42 accident records had been completed in October 2015 where people had sustained varying degrees of injuries. Some falls had been unwitnessed. The previous manager and the provider had not informed us of these events and a safeguarding incident that had occurred at the service. Informing the Commission of incidents such as alleged abuse and serious injuries is a legal requirement.

This is a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009. The provider did not notify us of incidents as they were required to do.

We looked at the way the provider assessed the quality and safety of the service. We saw that checks and audits were completed regularly throughout the year. The checks included, for example, accidents and incidents, care plans, medication, fire safety and equipment. When issues were identified through these checks, action was not taken to reduce any further risks. Audits for medication, care plans and monitoring the quality and safety of equipment and environment did not reflect the issues and concerns we found during our checks on the documentation and accuracy of information. The audit systems were poor and not sufficiently robust to ensure people were provided with safe quality care. The provider was unaware of the failings in care we had identified at this inspection.

We saw there was a lack of consistency in involving people and/or their representatives in making decisions about their care and support needs. People did not consistently receive individualised care and the information recorded in the care plan was not regularly carried out in practice. Staff were kind in their approach but sometimes focussed on the task and not the individual. People did not receive person centred care.

Risks to people were not being consistently identified, managed and reviewed by the manager and provider. For example, one person had lost a significant amount of weight; an assessment of their risk of malnutrition had not been reviewed. Actions needed to reduce the risk of further weight loss had not been monitored. Staff told us the actions they needed to take but confirmed these were not consistently carried out. Checks had not been completed by the provider to ensure people's well-being. This meant the manager and provider did not consistently promote people's welfare and safety.

The provider had not raised safeguarding referrals with the local authority when there had been incidents of suspected abuse and did not recognise the need to do so. The provider did not carry out any investigations or implement any action to reduce the risks to people. Lessons were not being learned to ensure people were protected from further harm.

The provider did not ensure staff were suitably trained or supported through regular supervision to make certain the care and support they provided to people was safe and effective.

These concerns are a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems in place to regularly assess, monitor and improve quality were ineffective.

Staff knew about the whistle blowing policy and the way they could raise their concerns when they felt the need to do so. Staff told us that sometimes meetings with the previous manager were arranged but these were not on a regular basis. We saw the current manager had arranged a staff meeting to take place. They told us meetings would be arranged at regular intervals or when the need for discussion was needed.

Since the last inspection there had been a change in the management arrangements of the service in that the registered manager had resigned from the position. A new manager had been recruited and had begun working three days prior to this inspection. The new manager had identified areas for improvement and had started to implement some changes. Staff and visitors told us they had met with the new manager and found them to be helpful and supportive in the short while they had been in post.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 (RA) Regulations 2014 Dignity and respect People were not treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider did not notify us of incidents as they were required to do.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way.

The enforcement action we took:
We issued a warning notice to the provider telling them to make immediate improvements to the quality and safety of care they provided to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems were not established and operated effectively to ensure compliance with the requirements.

The enforcement action we took:
We issued a warning notice to the provider telling them to make immediate improvements to the quality and safety of care they provide to people.