Atlantis Medicare Limited

Lyndhurst Residential Care Home

Inspection report

120 Manchester Old Road
Middleton
Manchester
Greater Manchester
M24 4DY

Tel: 01616439222

Date of inspection visit:
04 August 2022
08 August 2022
10 August 2022
16 August 2022
17 August 2022

Date of publication:
05 October 2022

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Lyndhurst Residential Care Home is a care home without nursing care, providing accommodation for persons who require personal care for up to 42 people. The service provides support to older people some of who are living with dementia. At the time of our inspection there were 31 people using the service. The care home accommodates people across two floors in one building.

People's experience of using this service and what we found
People were at risk of harm because of failures to identify and address safety concerns. Systems were not in place to ensure people received safe and appropriate support to take their medicines. Staffing in the home was not safe and relied upon agency carers on each shift to administer medication. Infection prevention control practices were not always being followed; however, people were supported to have visitors. Recruitment practices did not follow necessary processes and risks relating to people's health and the overall environment were not being appropriately managed. The manager was unable to provide any examples of lessons learned. Systems were in place to safeguard people, however the policy which was in place to support this required updating.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. Although the policies and systems in the service supported this practice and necessary deprivation of liberty safeguards (DoLS) referrals were being made, we found an example where best interest decisions were not in place.

Various application and intake records were being completed in retrospect, whilst other records were not as person centred as they should have been, and people did not always receive person centred care. Complaints were not always being appropriately recorded and the complaints policy required updating. Peoples communication needs were being met. An activities coordinator was employed by the home, but they were not always able to offer activities to people as they had to also conduct caring duties when the service was short staffed. Peoples end of life wishes had been considered.

Continuous learning was not consistent, audits were not always robust, and the provider was not conducting any audits within the service. Incidents were not always reported to the Care Quality Commission (CQC) when they should have been, and a variety of documents were either not in place or required updating. The provider failed to fulfil the assurances they had given us on day one. Staff feedback about the service was poor. Surveys had been conducted in 2021 but had not been analysed.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection and update
The last rating for this service was requires improvement (published 2 September 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At

this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, medication management, poor management, poor record keeping and poor care. A decision was made for us to inspect and examine those risks.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, responsive and well-led sections of this report. You can see what action we have asked the provider to take at the end of this report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lyndhurst Residential Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to infection prevention and control (IPC), medicines management, risk management, person centred care, failure to send appropriate notifications to CQC, staffing, training, recruitment, complaints management and good governance.

We imposed two conditions on the providers registration, one to restrict admissions to the home and the second to ensure there is appropriate clinical oversight of medicines. We have also issued a warning notice in relation to poor governance. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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. Details are in our safe findings below.	**Inadequate**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Lyndhurst Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the IPC measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector, a pharmacy specialist and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Lyndhurst Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Lyndhurst Residential Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with CQC to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was not a registered manager in post. A manager was in post, we have referred to them as 'the manager' throughout

this report.

Notice of inspection
This inspection was unannounced. Inspection activity started on 4 August 2022 and ended on 17 August 2022. We visited the location on 4, 8 and 10 August 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider did not complete the required Provider Information Return (PIR) and had requested an extension to allow this to be completed. This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and four relatives about their experiences of the care provided. We spoke with ten members of staff including the manager, deputy manager, senior care workers, care workers, domestic staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records, which included detailed reviews of three people's care plans and multiple medication records. We observed medicines administration and checked medicines storage. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last inspection the provider had failed to demonstrate medicines were effectively managed. This was a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Medicines were not managed safely. Medicine Administration Records (MAR) had missing signatures making it unclear whether doses had been missed.
- The home did not have a safe process to check what medicine a person should be taking when they came to the home. Not having an accurate record increases the risk of medicine errors.
- Care records were not in place for some medicines. For example, there were no care plans for 'when required' medicines to guide staff in how they should be given. Care plans for medicines given covertly (hidden in food or drink) did not guide staff in how to administer them safely.
- Medicines were not always stored safely. Temperature records for the medicines' fridge were out of range and staff had not taken any action. Medicines to be returned to pharmacy were not stored securely. We found missing high risk medicines and the home could not explain where they were.
- Relatives told us, "There have been issues with medicine going missing and they have administered medication incorrectly at least once" and "They keep getting the medicines mixed up."

Systems were either not in place, not being followed or not robust enough to demonstrate medicines safety was effectively managed. This placed people at risk of harm. This was a continued breach of Regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure that effective systems were in place to assess, monitor and mitigate the risks to people's health and safety. This was a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- People were at risk of harm as health and safety risks were not being appropriately managed. There were a number of environmental risk assessments in place, most of which need updating.

● Personal Emergency Evacuation Plans (PEEPs) were either not in place or were not up to date. PEEPs provide information to staff and the emergency services for how to evacuate people in the event of an emergency. 7 people did not have a PEEPs in place in the PEEPs folder. Some people's PEEPs had not been updated since 2018.
●The fire risk assessment appeared to have been carried out in March 2022 but no necessary actions had been completed from this. Not all staff were up to date with fire training. Following the first day of inspection, we referred the home to the local fire prevention team.
● Window restrictors were not in place in some rooms on day one of the inspection. This posed an increased risk of falling through a window for people living on the first floor. On day three the manager had ensured this was rectified.
● Legionella risk assessments were in place, though empty rooms with stagnant outlets were not being flushed regularly.
● Accidents and incidents were not always being consistently recorded, including when people had experienced falls. The accidents folder had not been completed since 1 June 2022.

Systems were either not in place or robust enough to demonstrate safety and records relating to risk was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Infection prevention practices were not always safe. We witnessed several staff members not wearing face masks appropriately.
● We found toiletries in communal areas which had not been identified as belonging to a specific person who used the service. This posed an infection risk.
● We could not be sure a robust cleaning regime was in place or being followed. Cleaning records for people's bedrooms were not always completed and there were no cleaning records for communal areas/items including communal bathrooms, hoists or high touch areas.
● The provider's care of substances hazardous to health folder was not up to date and did not fully reflect the products being used. This means that should an error arise with these products; staff may not know how best to act.

The provider had failed to ensure appropriate processes were being followed regarding IPC practices. This put people at risk of infection and significant harm. This was a breach of Regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager told us they would look to rectify these issues.

Staffing and recruitment
● Staffing levels was not safe and a number of staff were not up to date with their necessary training courses.
● There was a high use of agency staff being used every day to administer medication, at the point of inspection there were no permanent seniors working in the home. This caused issues and errors in medicines administration.
● People did not always receive timely support from staff. We reviewed two days' worth of call bell wait times and found 51 call bells took over 10 minutes to respond to, and 28 of these took over 20 mins to respond to.
● People told us there were delays in staff providing support. People's comments included, "I'm waiting to go for a cigarette, but they are too busy to take me at the moment." and "They are short staffed. A lot of

them have left. There aren't enough of them."
● Relatives and staff told us they had concerns about staffing levels at the home. One relative said, "The Staff are all changing. A lot have left and gone to the care home up the road. They have agency staff a lot now. It is very concerning when it is your Mum and she can't speak for herself." Staff comments included, "At the moment they (staffing levels) are appalling - there is no staff, it's all agency."

We found no evidence people had been harmed, however, the provider had failed to ensure appropriate staff were deployed to provide required care and that staff were up to date with necessary training. This put people at increased risk of harm. This was a breach of Regulation 18(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems were not always in place to support the safe recruitment of staff.
● One staff member did not have all necessary pre-employment checks in place before starting in their role, including references and a Disclosure and Barring Service (DBS) check. A DBS provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. This incomplete recruitment file also took over a week to be provided after several requests.
● Two staff members had gaps in employment which had not been addressed.

The provider had failed to operate an effective recruitment process. This placed people at risk of harm. This was a breach of Regulation 19 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was mostly working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. However, we did find one example where a person had a sensor mat in place without the appropriate paperwork to support this.

Learning lessons when things go wrong
● During our inspection the manager was not able to provide any examples of lessons learned that had taken place.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes were in place to safeguard people from the risk of abuse. A safeguarding policy and procedure was in place and included information on how to escalate concerns, though this required updating. The manager assured us this has been done.
● Staff were able to provide examples of what they would report to safeguarding.
● Incidents had appropriately been referred to the local safeguarding team to keep people safe.

Visiting in care homes

- People were supported to have visitors in line with current government guidance.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider had failed to demonstrate clear and accurate records were being maintained in relation to the care and support people received. This was a breach of regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● People's care records were not always up to date. Staff were completing charts retrospectively in relation to people's fluid intake, topical creams and thickener. We could not always be assured the information recorded was accurate.

The provider had failed to ensure good governance. This placed people at risk of harm. This was a continued breach of Regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's care records were not person centred and indicated people did not always receive person centred care.
● Assessments were not always carried out prior to people being admitted to the service to identify people's care and support needs and show how the provider had made the decision that they could meet these needs. Three people's care records did not have a pre-admission assessment in place.
● Shower records indicated people were not regularly being showered.
● Care records were not always in place for people with mental health needs, such as depression. This meant staff did not always have the necessary information in how to support them.
● Medicines practices at the home were not person centred. People received their medicines based on staff availability, rather than accommodating their choices. We found four people had not had their antibiotics given correctly and we found eight people had not had all their medicines as they were out of stock.
● Peoples comments included, "Sometimes I get my medication on time and sometimes I don't. When there are two staff and 24 people to sort out, they aren't going to manage. I have a butane patch. She's just changed it this morning. Sometimes they are a day late to change it.." and They've woken me up in the early hours to give me my meds a couple of times, I think they forgot.."

The provider had failed to ensure systems and processes were in place and being followed to ensure that

people received person centred care. This placed people at risk of harm. This was a breach of Regulation 9 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● Systems were not in place to ensure complaints were received and acted on appropriately.
● Complaints were not always being appropriately logged which made it difficult to understand if they were being responded to appropriately.
● The home had a complaints file, which had 2 complaints recorded in 2022. However, we were advised there were other concerns which had been raised and had not been logged. The deputy manager confirmed various issues had been raised but not logged in the folder. A number of complaints and concerns raised by CQC were also not being recorded in the complaints file.
● The home had a complaints policy in place, however this required updating.

We found no evidence people had been harmed. However, the provider had failed to ensure systems and processes were being followed to ensure complaints were being appropriately logged and recorded. This was a breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● The manager understood the need to ensure people were able to access information in a format suitable for them. The manager told us they communicate with picture cards and could obtain information in large print and also could access resources such as audio books if needed.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● The service had an activities co-ordinator who planned and led on a variety of activities for people living in the home. However, the activities coordinator was not always able to deliver activities as they were required to take on care duties when the home were short staffed. One relative told us "Last week even the activities worker was doing caring rather than what she should be doing as they are short staffed."
● Activities were not always taking place to provide people with stimulation. On day one of the inspection the activities coordinator was assisting with care and on day three the activities coordinator was not on shift.
● People were supported to have visits from their loved ones.

End of life care and support
● No one was in receipt of end of life care at the time of the inspection.
● People had end of life care plans in place.
● The service had an end of life policy in place, which detailed the expectations around end of life care.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care

At our last inspection the provider had failed to ensure audits were sufficiently robust to identify the shortfalls found. This was a breach of regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

●The provider's oversight of the service was ineffective. Systems were not in place to support the monitoring and improvement of the service.
● Continuous learning and improving care was not consistently taking place. Audits were either not taking place or were not effective in identifying the issues we found.
● The provider was not conducting any quality assurance checks within the service.

The provider had failed to ensure good governance. This placed people at risk of harm. This was a continued breach of Regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Although management were reporting necessary safeguarding, we found incidents which had not been reported to CQC when they should have been.

We found no evidence people had been harmed as a result of us not being notified. However, systems were not in place to ensure notifications were submitted. This placed people at risk of abuse. This was a breach of Regulation 18 (1) of the Care Quality Commission (Registration) Regulations 2009.

● The manager was aware of their responsibility under the duty of candour and spoke about being open and honest when things go wrong. However, the management had not always taken necessary action to appropriately report when incidents had happened.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Due to numerous concerns identified, assurances were given by the provider after first day of inspection, however these had not been followed through with when we returned for a second day.
● Various records were either not made readily available when requested or were not in place.
● The manager had information on their personal laptop which was not on-site during the first day on inspection. A staff member took a photograph of someone's MAR chart on their personal phone and we witnessed personal records left in an unlocked room.
● A variety of policies and documents required reviewing and updating.

We found no evidence people had been harmed, however, systems were either not in place or robust enough to demonstrate records and governance was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service did not have a registered manager in post. The previous registered manager de-registered in March 2022. At the time of inspection, there was a manager in post, however, since the inspection we have been advised this manager has now left the service and a new manager has been appointed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People using the service did not always receive good outcomes.
● Staff feedback comments about the service and management was negative. Comments included, "It can be [a good place to work] and it was, but it's not at the minute" and "I used to love working here, but I don't at the moment. I love talking to the people and listening to their stories, I just don't like working here at the moment, we don't have time to do anything."
● Resident and relative surveys were carried out in 2021, however, no analysis of these results had been completed.
● The manager told us they had not conducted any meetings with residents and relatives since taking up the post and could not provide any evidence of any recent meetings which had taken place. The manager told us they would schedule a residents meeting without delay. Staff meetings had been taking place before the appointment of the new manager, however, none had taken place since they joined the business. The lasts staff meeting was dated 24 May 2022.
● The service worked in partnership with the local authority and various health teams.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not sent necessary statutory notifications to CQC when regulations deemed them necessary. This put people at increased risk of abuse. This was a breach of regulation 18 (1) (2) (e) (f) of the Registration Regulations 2009. Notifications of other incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people's care records were person centred and they received person centred care that met their needs. This put people at increased risk of harm. This was a breach of regulation 9 (1) (a) (b) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure all necessary processes were being followed and paperwork was in place regarding IPC. This was a breach of regulation 12(2) (h) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014. Safe care and treatment.

The provider had failed to ensure risks were being appropriately assessed and managed

This put people at increased risk of harm.

This was a breach of regulation 12(2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to ensure systems and processes were being followed to ensure complaints were being appropriately logged and recorded. This was a breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure that staff recruitment was robust meaning that safe recruitment procedures had not always been followed. This was a breach of regulation 19 (2) (a) (b) 3 (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that adequate

staff was always available to provide required care, and that required training had been completed.

This was a breach of regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure medicines were being safely managed. This put people at risk of harm. This was a breach of regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment

The enforcement action we took:

A notice of decision was served on the registered provider under Regulation 12, to restrict admissions to the service and to ensure a suitably qualified, skilled and competent professional, who may be a qualified nurse or pharmacist, undertakes oversight of medicines management.

The provider had failed to ensure the proper and safe management of medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance Records were not always completed and up to date and quality assurance systems were not robust. This put people at risk of harm. This was a breach of regulation 17(2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The enforcement action we took:

A warning notice was served on the registered provider under Regulation 17

The provider had failed to make certain that effective systems and processes were established and operated effectively to ensure the service is compliant with the

requirements of Regulation 17 (good governance) of the Health and Social care act 2008 (Regulated Activities) 2014.