Viomar Care Homes Limited

The Old Vicarage 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**

Summary of findings

Overall summary

About the service: The Old Vicarage Residential Home is a residential care home that was providing personal care to 13 people aged 65 and over at the time of the inspection.

People's experience of using this service: People were not kept safe because all their risks were not assessed and planned for and their medicines were not safely managed. These were continued issues from the last inspection. Not enough improvements had been made since the last inspection to ensure people received a safe and good quality service.

There were not enough staff to safely meet people's needs. The provider acted to increase staffing levels following our feedback but they had not identified this issue for themselves.
The providers systems to monitor and improve the quality and safety of the service were still not effective. Lessons had not always been learned when things had gone wrong.

People's choices and preferences were not always respected because there were not enough staff on duty to facilitate people's choice. People were not always involved in their care planning so did not have the opportunity to voice their preferences.

Improvements had been made to ensure people consented to their care.

People enjoyed the food on offer and had choices of meals. People were happy with the way staff treated them.

There was a new manager since the last inspection and they were in the process of registering with CQC. People knew the manger and staff felt supported.

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

Rating at last inspection: At the last inspection the service was rated Inadequate. The report was published 14 September 2018 and the supplementary report (including enforcement action taken) was published 1 December 2018.

Why we inspected: This was a planned inspection based on the previous rating.

Enforcement: Full information about CQC's regulatory response to the more serious concerns found in inspections is added to reports after any representations and appeals have been concluded.

Follow up: The overall rating for this service is 'Inadequate' and the service remains 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. 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.

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 effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
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**

The Old Vicarage Residential 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by one adult social care inspector 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:
The Old Vicarage Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Old Vicarage Residential Home accommodates up to 15 people in one adapted building.

The service is required to have a manager registered with the Care Quality Commission. 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. There was a manager in post but they were not yet registered with the Care Quality Commission. They had started the application process.

Notice of inspection:
The inspection was unannounced.

What we did:
We used the information we held about the service to formulate our inspection plan. This included statutory notifications that the provider had sent to us. A statutory notification is information about important events which the provider is required to send us by law. These include information such as safeguarding concerns and deaths. We also sought feedback from commissioners of the service and looked at information we had received from the public.

We had not requested a Provider Information Return since the last inspection. This is information providers must send us to give us key information about the service, what it does well and improvements they plan to make.

During the inspection, we spoke with four people who used the service and three people's visiting relatives. We did this to gain their views about the care and to check that standards of care were being met. We observed how staff interacted with people in communal areas and we looked at the care records of five people who used the service, to see if their records were accurate and up to date. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with four members of care staff, the chef, a domestic assistant and the manager. We also looked at records relating to the management of the service. These included three staff recruitment files, staff rotas, training records and quality assurance records.

Following the inspection, we asked the manager and provider to send us some additional information that was not available during the inspection. We received this information after the inspection visit.

Inadequate

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management
• At the last inspection we found that risks to people's safety and welfare were not always suitably assessed and managed and this was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• At this inspection we found that whilst improvements had been made in some areas, people remained at risk of harm because all their risks were not assessed, planned for and minimised.
• Five people who used the service had diabetes. None of these people had a care plan or risk assessment in place to guide staff on how to manage this health condition, which left people at risk of harm as staff did not have the guidance they needed to manage the risks associated with the condition.
• There was a whiteboard in the kitchen which detailed who had diabetes. However, this only included four people, not five, and it did not state what type of diabetes people had and how staff needed to support them. A staff member said, "I'll be honest, I wouldn't know who was tablet controlled or diet controlled." This meant staff were not clear who had diabetes and what this meant for the individual.
• Some people required increased monitoring because they were at risk of constipation. This was a known health condition, however staff were not completing any form of monitoring and therefore people were at increased risk of poor health through the lack of management of specific health conditions.

The above evidence shows a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Since the last inspection, improvements had been made to way people's mobility risks were assessed and managed. People now had suitable plans in place and there was equipment available to help people move safely including a hoist, handling belts and stand aids.

Using medicines safely
• At the last inspection, people's medicines were not safely managed to ensure that they received them as prescribed and this was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• At this inspection we found that people's medicines were still not safely managed.
• Some people were prescribed 'as required' medicines. Suitable protocols were not in place to guide staff on how to administer these medicines to people who were unable to request them. This was a continued issue from the last inspection and the provider had still not ensured that staff had the required guidance in place to safely administer 'as required' medicines.
• We found that one person had not been receiving their prescribed laxative medicine twice daily as prescribed despite this being clearly being recorded on their Medicines Administration Record (MAR). No staff had identified this issue or acted to ensure the person received their medicine as prescribed and this

meant the person was at risk of harm.
• There were no records of the amount of stock for each medicine people were prescribed. There was no record of regular stock counts or stock checks of people's medicines and no 'carried forward' balances were recorded on MARs and no quantity received balances were recorded. This meant there was a risk of people running out of stock of their medicines as there was no running balances to alert staff when stocks were becoming low and there was a risk of gathering excess stock. It also meant the provider could not be sure that people's medicines had been administered as prescribed as records were not accurately maintained.
• Some people were prescribed topical creams. We were told that body maps were in people's bedrooms that directed staff where to apply prescribed creams. However, we found these were not always accurate and up to date and contained incorrect information.
• Some people were not receiving their prescribed topical creams because ineffective medicines management systems were in place and staff were not sure whether the cream was in stock or whether it had been discontinued.
• We found a number of examples of unsafe and improper management of medicines that was not in line with the NICE guidance, "Managing medicines in care homes". NICE is the National Institute for Health and Care Excellence which aims to improve health and social care through evidence-based guidance. An example was that handwritten MARs had not been checked or countersigned by a second person, trained in medicines administration. This significantly increased the risk of medicines errors and showed that medicines were not safely and properly managed.

The above evidence shows a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• At the last inspection there was enough staff to meet people's needs but the registered manager had not ensured that there was a member of staff who was trained to administer medicines on duty at all times so people did not always have access to medicines.
• At this inspection we found action had been taken to ensure medicines trained staff were always on duty however there was not always enough staff to support people safely.
• Since the last inspection, some people's needs had increased and some people now required two staff and equipment to help them move safely and to support them with personal care. The provider had not taken this into account with regards to staffing levels and staffing numbers had not increased when people's dependency had increased.
• At tea time there were two staff on duty. Staff were expected to warm up and serve food and drinks, support people to eat, administer medicines, support people with their personal care needs and also monitor people who were at high risk of falls. It was not possible for two staff to complete all these tasks safely.
• Whilst two care staff were supporting one person to move, they were unavailable to support others. We observed that the lounge was unsupervised for periods of time whilst staff were busy supporting people and no-one was available to respond to sensor alarms or support people who were at high risk of falls. This showed there were not enough staff to safely meet people's needs.
• Staff confirmed our observations and told us they were not able to provide safe care and support with only two staff on duty. Staff comments included, "I definitely think we need more staff. They [people] aren't getting their needs met and not getting the attention they need", "There is a worry when there is only two of you. There is no-one spare when you are both dealing with [People who require two staff]" and "I think it's harder now because more people need two staff to support them. You'd feel responsible if anything happened to the others."
• The new manager had completed a dependency tool which helped to inform the number of staff required to meet people's needs, based on the dependency of people living at the home. This was completed in

December 2018 and indicated that four staff were required to provide a safe and good quality service to people. However, only two staff were on duty apart from a period of three hours in the morning when three staff were on duty. This meant the provider had not ensured there were enough staff to safely meet people needs.

The above evidence shows a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider took action to increase staffing levels following our feedback but they had not identified this issue for themselves.
• At the last inspection, the provider could not be sure that staff employed were suitable to work with people who used the service. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• At this inspection we found that enough improvements had been made so that the provider is no longer in breach of this regulation.

• Further improvements were required to ensure that staff recruitment procedures were thorough and robust because not all new staff had two references recorded on file and not all new staff had a reference from their last employer.

Systems and processes to safeguard people from the risk of abuse
• At the last inspection we found that people were not always safeguarded from abuse and improper treatment. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• At this inspection, we found that enough improvement had been made so that the provider was no longer in breach of this regulation.
• Staff and the manager understood their responsibilities in safeguarding people from abuse and described the required action they would take to keep people safe. However, we saw there were some gaps in safeguarding training for staff.
• The new manager had implemented systems to ensure that safeguarding concerns were recognised and reported to the local authority safeguarding team, when required, to keep people safe.
• Since the last inspection, no safeguarding incidents had occurred at the service.

Learning lessons when things go wrong
• Whilst some improvements had been made since the last inspection, there were still three continued breaches of regulations. This showed that the provider had not learned lessons and made swift improvements when people's safety was at risk.

Preventing and controlling infection
• At the last inspection, people were not always protected from the spread of infection.
• At this inspection, improvement had been made.
• We observed the service was clean and tidy and we saw domestic staff carrying out their duties during the inspection.
• We observed staff followed safe practices including wearing personal protective equipment (PPE) when required.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

RI:□The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
• At the last inspection, people's consent was not always sought and when people lacked the mental capacity to give such consent, the service had not acted in accordance with the Mental Capacity Act 2005 (MCA). This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• At this inspection we found that enough improvements had been made so that the provider was no longer in breach of this regulation.
• The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
• We found that people's capacity to consent to their care had been assessed and decisions had been made in people's best interests when required.
• When a third party had legal decision-making powers for people who lacked mental capacity, the manager had sought evidence of this and recorded it in the person's care plans. This ensured that people's legal and human rights were respected and only people with the correct legal powers made decisions on behalf of others.
• People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
• We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
• We found that when the service was restricting people's liberty, this had been identified and authorisation had been applied for, in line with the MCA.
• However, staff were not aware of which people had authorisations in place so they could not ensure they were working in line with these authorisations.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs and choices were not effectively assessed prior to them moving to the service, to ensure their needs could be met.
• One person had been living at the home for almost six weeks and they had very little information in their care plan, which meant staff did not have all the information they needed to meet the persons needs and choices.

• The person was planned to receive short term care but later became a permanent resident. A thorough and holistic assessment of their needs and choices had not been completed at any stage. Some risks had been assessed, however, their holistic needs and choices had not been considered. This meant there was a risk that their needs and choices would not be effectively met.

Staff support: induction, training, skills and experience
• At the last inspection, the provider had not assured themselves that staff were suitably qualified, skilled and competent. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• At this inspection, we found improvements had been made but further improvements were required.
• The manager was using a training matrix to keep track of training staff had received and when updates were due. This matrix showed some gaps in essential staff training such as safeguarding adults. It also did not include some newer members of staff though they told us they had completed training as part of their induction. The manager had plans in place to introduce additional training and competency checks for staff though these had not yet fully commenced.
• The manager was trained to provide moving and handling training to staff. However, they told us they had not delivered the training to new staff because there was no space available to complete it. This meant the manager was having to oversee staff practice and complete additional competency checks to ensure staff were suitably skilled because they did not have the facilities to provide the practical training.

Staff working together and with other agencies to provide consistent, effective, timely care;
• Staff told us they worked together well to deliver effective care. However, a staff member commented, "There's no written handovers so it's easy to miss things." They felt it would be beneficial to have a written record for handovers so staff could refer to information to refresh their memory and also for accountability. We spoke to the manager about this and they told us they were aware that improvements were required and planned to introduce a more thorough, written handover record.
• A communication book and 'memo book' were used to communicate important messages and changes in people's needs between staff and management and we saw staff referring to these to ensure they had information they needed.

Supporting people to live healthier lives, access healthcare services and support
• People told us they had access to healthcare professionals when required. One person said, "The home makes any appointments for me. I only need to ask them if I think I need anything."
• People's records showed they had accessed various professionals including nurses, physiotherapists and chiropodists.
• However, some specific health conditions were not always well managed. People with diabetes did not have specific care plans and professional guidance in how to manage their conditions had not been sought.

Supporting people to eat and drink enough to maintain a balanced diet
• People told us they enjoyed the food on offer and had choices. Comments included, "The food is very good here and you get a choice of what to have" and "The food is lovely here and they will even change it and get something else for you if you don't fancy what is on the menu."
• Since the last inspection, improvements had been made to the way in which people's nutritional risks were monitored. When food and fluid monitoring was required, this was in place and regularly monitored by the manager who acted when required. For example, staff had been reminded via a communication book to encourage fluids and fruit to one person who was not meeting their fluid target and thanked for supporting another person to successfully meet their fluid target.

Adapting service, design, decoration to meet people's needs

• Since the last inspection some improvements had already been made and some were in progress. The provider had plans in place to make further improvements, including replacing all doors, windows and carpets and installing hand rails to make the garden more accessible.
• The bathrooms were also due to be refurbished which would include the introduction of a walk-in shower to enhance people's comfort and experience.
• The home is small and some bathrooms were used to store equipment. There were plans in place to try and utilise other areas of the home for storage and we saw that work had commenced to try and resolve this issue.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

RI:□People did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
• People could not always make choices and decisions about their care because the lack of staff impacted on care provision. For example, some people required two staff to support them to move or with personal care and dressing. Staff told us these people could only have a bath or shower during the three-hour time period when three staff were on duty. This meant they were unable to choose when to receive personal care because there was not always enough staff to facilitate their preferences. A staff member said, "People should be able to choose [when to have personal care] but you're just not able to do it, you have to ask them to wait."
• A staff member said, "The 'twos' are always done first when you come on shift." This meant that people did not always have a choice about the time they received personal care because care was sometimes 'task focussed' rather than focussed on people's choices or preferences.
• There were limited opportunities for people to express their views and be involved in their care. People had not been involved in writing or reviewing their care plans to ensure their wishes and preferences were captured and there had been no meetings for people to share their feedback and express their views.

Ensuring people are well treated and supported; respecting equality and diversity
• People told us they were happy with the care they received and the way staff supported them. Comments included, "The staff are all very good, nice and friendly. You could not have any better and they always make time to chat to you" and "All very good. They have a laugh with you and all have a good sense of humour. Staff are very caring and very friendly."
• Relatives felt people were treated well by caring staff. Comments included, "There's a lot of new staff here and it's getting to know them and them getting to know [my relative]'s ways. Some are better than others in their approach but all are very nice and kind" and "All the staff here are very nice and have been so kind and helpful towards [my relative] and make me feel welcome when I visit." Our observations confirmed that staff treated people with kindness and compassion when interacting with them.
• People's diverse needs were not always fully assessed and considered. People's religion was asked and people were supported to follow their faith if they chose to. However, other diverse needs such as sexuality were not considered.

Respecting and promoting people's privacy, dignity and independence
• People told us their privacy and dignity were respected. One person said, "Oh yes always, that is fine, they [staff] are very considerate and always close the door when bathing me or taking me to the toilet and waiting outside." Our observations confirmed people's privacy and dignity was respected.
• People's independence was respected by staff. One person said, "I can do most things myself but they do help to dress me and close the curtains and my door when doing so." Staff described how they promoted

independence by letting people do what they could for themselves.

Requires Improvement

Is the service responsive?

Our findings

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

RI:□People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• At the last inspection we observed there was little activity or stimulation for people and at this inspection we observed the same. A relative said, "Activities are few and far between. They have had singers and they have promised more."
• Care staff were expected to provide activity and stimulation for people within the day. However, with only two care staff on duty for most of the time, staff told us and we observed this was difficult to achieve as they did not have time. We did observe a group game; however, this was facilitated by a staff member providing one to one support specifically to one person.
• People were not always involved in the planning and review of their care. This meant their wishes and preferences may not be captured and met. We found there was little personalised information to help staff to provide person-centred care and support. However, some staff did know people well.
• Most care plans were not accurate and contained out of date information. A staff member said, "I don't read all of the care plans because I'm not a senior but the seniors say it's hard to find the information you need in the care plans." The manager was aware of the need for care plans to be updated but they had not yet been completed.

Improving care quality in response to complaints or concerns
• People felt able to raise any concerns or complaints. One person said, "I would speak to my carer when she comes around." Staff knew how to respond to complaints and what action to take.
• A suitable complaints policy and procedure remained in place and we saw that when complaints had been received, they had been addressed and responded to.

End of life care and support
• At the time of the inspection, no-one was receiving end of life care. However, we found that most people's wishes for care and treatment at the end of their lives had not been considered or planned for. This meant there was a risk that people may not receive the care or treatment they would wish for because they had not been asked at a time they were able to communicate their wishes.

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; Continuous learning and improving care

• At the last inspection, systems and process were not established or operated effectively to ensure that people received a good quality and safe service. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• At this inspection we found that despite the enforcement action we took following the last inspection, governance systems were still not operated effectively to continually assess, monitor and improve the quality and safety of the services provided. The provider's actions had not been effective in identifying the areas for improvement in a timely way and mitigating the risks to people and many issues from the last inspection were still apparent. This exposed people to the risk of harm.

• For example, the provider's own medicines audit had not identified all the issues we did during the inspection and therefore had not ensured the necessary improvements were made. A further example was the provider's own systems had not identified that some people's risks had not been assessed or planned for and they had not been successful in ensuring the most serious risks to people were mitigated.

• The manager had started to implement some governance systems; however, these were not yet fully embedded in the home. The manager told us about several audits that were required and planned to be in place by the end of March 2019. However, this was seven months after the first inadequate rating and there was still not a consistent approach to quality and safety embedded in the home.

• A relative told us they met with the manager some weeks prior, to raise some issues regarding the care of their relative. The manager had assured that a new care plan would be implemented and staff would be made aware of changes to the plan of care. However, we found that not all staff were aware of the changes and there was no specific care plan in place, despite these assurances being offered to a relative. This showed that feedback had not been acted upon to ensure improvements.

The above evidence shows a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; and how the provider understands and acts on their duty of candour responsibility;

• There was a new manager who was in the process of applying to become the registered manager. The manager had been in post for eight weeks at the time of our inspection however had made limited progress at improving the governance and systems to monitor and improve the quality and safety of people's care.

• At the last inspection we found that an incident of abuse had occurred and we had not been notified of this event, as required by law. This was a breach of Regulation 18 of The Care Quality Commission (Registration)

Regulations 2009 (Part 2).
• At this inspection we found that the manager was aware of their responsibilities in notifying us of certain events and we had received the required notifications, so there was no longer a breach of this regulation.
• At the last inspection the registered manager at that time could not demonstrate an understanding of their responsibilities in relation to duty of candour and there had been a breach of Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we spoke with the new manager about duty of candour and they demonstrated an understanding of their responsibilities and told us how they would ensure compliance with this regulation. Since the last inspection, there had been no incidents that were duty of candour applicable.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• Improvements were still required to the way in which people and relatives were engaged and involved in the developments of the service. No regular residents or relatives' meetings took place and no regular review meetings with people took place either.
• The manager was aware of this and told us they were in the process of arranging a resident and relatives' meetings on a weekend when more people would be available to attend.
• The manager had also implemented a newsletter to help keep people and relatives updated on changes occurring at the service.

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 People's risks were not always assessed and planned for which left them at serious risk of harm. People's medicines were not managed safely which left them at serious risk of harm.

The enforcement action we took:

We urgently imposed conditions on the provider's registration to require them to take action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to safely meet people's needs.

The enforcement action we took:

We urgently imposed conditions on the provider's registration to require them to take action and to restrict admissions and readmissions without the prior consent of the CQC.