Wellbeing Residential Ltd

Chevington House

Inspection report

36 North Road
Bourne
Lincolnshire
PE10 9AS

Tel: 01778421821
Website: www.wellbeingresidential.co.uk

Date of inspection visit:
16 January 2019
17 January 2019

Date of publication:
16 April 2019

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 service provides accommodation and personal care for up to 16 older adults and people living with dementia. There were 16 people living in the service on the day of our inspection.

People's experience of using this service:

• The registered providers approach to safety and governance had deteriorated since the last inspection.
• Systems and processes for accepting new referrals for people receiving intermediary care were not in place which placed people at risk of avoidable harm.
• Risks to people's health were not being managed.
• Medicines were not being administered safely.
• Governance systems did not identify risks to people.
• People received nutritious and healthy food.
• People were cared for by staff who were kind and compassionate.

Rating at last inspection:

At the last inspection the service was rated Requires Improvement. Report published 26 September 2017.

Why we inspected:

This was a scheduled inspection based on the rating at the last inspection.

Enforcement:

Following the inspection, we took urgent enforcement action to restrict new referrals to the home via the intermediary transitional care service. In addition, we requested an action plan and evidence of improvement in the service. This was requested to help us decide what regulatory action we should take to ensure the safety of the service improves. You can see what action we told the provider to take at the back of the full version of the report.

Follow up:

We will continue to monitor the service and have asked the registered provider to send us a report every month to tell us about the ongoing improvements to safety and governance in the service. The registered provider has complied with this and has been submitting regular reports to the CQC.

The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into

'Special Measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

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 act 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 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.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We will have contact with the provider and registered manager following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

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**

Chevington House

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:

This inspection was carried out by one inspector.

Service and service type:

Chevington House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provides accommodation and personal care to 16 older adults and people living with dementia.

The service had 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.

Notice of inspection:

The inspection was unannounced.

What we did:

Prior to the inspection we reviewed information we had received about the service, this included details about incidents the provider must notify us about. We sought feedback from the local authority, the local safeguarding authority and other professionals who work with the service. We used this information to plan

our inspection.

During the inspection we spoke with four people, three care staff, the chef, the registered manager and the operations manager on the second day of our inspection. We also spoke with one visiting health professional. We reviewed records related to the care of six people. We looked at records of accidents and incidents, audits and quality assurance reports, complaints, and four staff files. We also looked at documentation related to the safety and suitability of the service. We spent time observing interactions between staff and people within the communal areas of the home.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management and using medicines safely:

• People were at risk of avoidable harm. At the time of the inspection the registered provider was providing an intermediary transitional care service to three people. An intermediary transitional care service is a short-term arrangement for people who have recently been discharged from hospital and require care and support to improve their health before returning home. We asked to look at the care records of the three people and found that only one person had care records in place. One person had been residing at the home for 10 days and had been identified by the local authority as being a high risk of falls. The registered persons had not taken the necessary steps to assess the identified risk to ensure that the person was safe.
• The registered provider did not have a policy or procedure relating to the admission of people for the intermediary transitional care service they were providing. Staff were provided with verbal instruction regarding how to provide care to people. The absence of a clear process to manage this service could cause harm to people because of the lack of planning and assessment. The registered manager told us that an electronic care planning system had been implemented and that they were not familiar with the system. They informed us that this was the main reason that assessments, care planning and risk assessments had not been done for the people using the transitional care service. Following the inspection, the registered manager implemented the appropriate risk assessments and care plans.
• Risks to people relating to swallowing and choking were not being managed. Care plans for one person were contradictory to the advice provided by the speech and language therapist which placed the person at risk of avoidable harm.
• People were at risk of becoming dehydrated. One person had an indwelling urinary catheter and was at higher risk of dehydration. The registered provider did not monitor or record how much the person drank. There was no guidance within their care plan regarding what amount of fluid they should drink to keep them sufficiently hydrated, which could cause harm to the persons health.
• People were at risk of harm because staff did not administer medicines safely. The service was not clear about its roles and responsibilities relating to 'as needed' medicines. Relevant national guidelines were not followed relating to medicines that people take on an 'as needed' basis for pain management. During the inspection visit the registered manager misunderstood the difference between homeopathic remedies and medicines prescribed on an 'as needed' basis and informed us that no one living at the home was administered medicines on an 'as needed' basis. We discovered that this was not factually correct. Staff told us that people were prescribed pain relief medicines to be administered on an 'as needed' basis. People were at risk of not receiving medicines when they were in pain.
• Staff were trained to ensure that medicines could be administered safely. The provider did not have a formal system in place for assessing the competence of staff following their training, the registered manager told us that they observed the staff administering medicines, but did not record that this had been done. The registered manager assured us that they would implement a formal system to assess competence.

• The above concerns demonstrated a failure to ensure that timely care planning had taken place to ensure the health, safety and welfare of service users, a failure to assess the risks to the health and safety of service users and a failure to ensure the safe management of medicines, which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment:

• Staffing levels at the home ensured that people received support when they needed it. The registered manager used a dependency tool to ensure that they had enough staff on duty to meet people's needs. One person told us, "Sometimes they are ever so busy, but generally there are enough staff." Call bells were responded to quickly. One person told us, "Sometimes you have to wait a minute or two, but they [staff] are usually quite quick."
• We looked at the recruitment records of three staff. The registered provider did not check employees full work history and references were not always obtained from previous employers. During the previous inspection on 11 August 2017 we found that in relation to staff recruitment records we checked the registered persons had not obtained a suitably detailed account of their employment history. The registered provider produced an action plan at the time and told us that they had implemented a system to improve this. These continued shortfalls had limited the registered providers ability to assure themselves that the applicant had previous good conduct and that they were suitable people to be employed.
• The above concerns demonstrated a failure to ensure recruitment procedures were established and operated effectively, which was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• Staff had Disclosure and Baring Service (DBS) checks in place. The DBS is a national agency that keeps records of criminal convictions.

Systems and processes to safeguard people from the risk of abuse:

• Staff received training regarding safeguarding adults and knew how to recognise and protect people from the risk of abuse. One staff member told us, "If I was to see abuse I'd report it to the manager, if they didn't deal with it, I'd go to the head office, I'd do it straight away."
• The registered provider had reported abuse to the local authority safeguarding team when it was identified.
• Where possible, people were supported to understand how to keep safe and raise concerns when abuse occurred.

Preventing and controlling infection:

• The registered provider had systems and processes in place to ensure that people were protected from the risk of infection. The environment was clean and odour free. The staff received infection control training and we saw that the registered provider ensured that antibacterial hand wash and single use gloves and aprons were available for the staff to use.
• People told us that staff wore protective equipment when delivering personal care. One person told us, "When I have a shower I always have a helper and they always wear aprons and gloves."

Learning lessons when things go wrong:

• The recurrent concerns identified in the recruitment process demonstrated that lessons were not learnt and necessary improvements were not made. This meant that people were placed at risk unnecessarily.

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

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

• At the previous inspection on 11 August 2017, risks to people from unprotected radiators was identified. The registered provider had not taken sufficient action to protect people from the risk of burns. We found on this inspection that people continued to not be protected from environmental risk.
• Sufficient precautions were not taken to ensure that people were protected from burns from hot radiators. During the inspection we saw that radiators were covered with a fabric protector which could easily be pulled off. One radiator cover was not sufficiently fastened which exposed a hot radiator. The covers were not sufficient to protect people from burns. The bath in one bathroom had a section of the panel removed exposing sharp edges which could cause significant injury to people. Immediately following the inspection, the registered provider acted to fix the panel and remove the risk.
• The above concerns demonstrated a failure to ensure that the premises were safe to use for their intended purpose, which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:

• Assessments of people's needs were not always done in a timely manner, which meant that there was a risk of people not getting the support in the way that they wanted.
• Peoples wishes and desired outcomes were not always recorded. For example, one person had been living at the home for four months following a spell in hospital due to a fall. They told us that it was their wish to return to their home when they had sufficiently recovered, but this was not recorded in their care plan. The registered manager and staff were working with health professionals such as the GP and physiotherapist, but the care plan did not reflect how they were doing this to achieve the persons desired outcome of returning home.

Staff working with other agencies to provide consistent, effective, timely care:

• The registered manager did not always make appropriate referrals to other professionals. For example, one person who was at risk of choking was on a special diet to reduce the risk. The registered provider had implemented the diet without consulting a speech and language therapist first, which placed the person at risk of choking.
• A visiting professional we spoke with was complimentary about the service provided at the home and described a positive working collaboration with the staff team. They told us, "The carers are very good in

that way, they do try and go the extra mile and seem kind and caring."

Staff support: induction, training, skills and experience:

• Staff received training which provided them with sufficient knowledge to carry out their duties.
• On the day of the inspection medicines training was being delivered to some of the staff team.
• New staff were expected to complete the care certificate. The Care Certificate sets out national common induction standards for social care staff. Staff were provided with a full induction when they began working at the home.
• Almost all staff working at the home either held or were working toward a nationally recognised qualification in care.
• Staff told us and records confirmed that they were provided with support and supervision meetings which enabled them to maintain their ongoing development.

Supporting people to eat and drink enough to maintain a balanced diet:

• During the inspection there was a nice smell of home cooked food. Food looked appetising and people appeared to be enjoying the lunch experience.
• People we spoke with told us that they liked the food and drink provided at the home. One person told us, "Overall the food is very good, we have a choice at breakfast and a choice of two mains at lunch, they [staff] come and ask me what I want at tea time, there is a variation of sandwiches and trifle; I never feel hungry."
• People benefited from an experienced chef who knew what people's nutritional needs were. The chef told us that they were flexible and responsive to what people wanted to eat and drink, they told us, "If it's in the cupboard and you want it you can have it. If it isn't in the cupboard I sometimes run to the shop in my two-hour break."

Supporting people to live healthier lives, access healthcare services and support:

• People were supported to access health professionals such as the GP, the district nurse and the physiotherapist.
• One person told us that they had seen a consultant from the local hospital three times in the previous four months and the local GP visits them every Wednesday morning. Another person told us, "If you want to see a doctor, you just speak to the boss who will get one to come in and see you."
• During the inspection we saw health professionals visiting people living at the home.

Ensuring consent to care and treatment in line with law and guidance:
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. 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 staff worked within the principles of the MCA and acted in their best interest when they were unable to make decisions for themselves.
• Staff had received training in MCA and asked people for consent to ensure that they were able to make

daily choices.
• During the inspection we saw staff asking people for their consent, for example we saw staff respectfully asking people if they wished to visit the toilet, or if they would like their feet elevating.
• 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). Three people living at the home had authorised DoLS in place. The provider had previously notified us about this.

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

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence:

• The registered persons did not always respect the privacy and dignity of people living at the home. For example, one person was living with dementia, confined to their bed and unable to communicate. Their bedroom was adjacent to the reception area and their bedroom door was wide open offering no privacy from others living at the home and visitors. There was no information in the persons care file to say who's decision it was to keep the door open. We asked that the situation be reviewed immediately to consider the persons privacy and dignity. The following day we found that the door was again wide open and the persons privacy and dignity was not being considered. The registered provider has since told us that the room layout had been altered to ensure that the persons privacy is maintained without the need to shut the door and isolate them.
• The registered provider did not always respect the confidentiality of people living at the home. The layout of the building meant that the registered manager did not have a designated office. Therefore, the public reception area was being used as the registered managers office. During the inspection we observed a private discussion about a person taking place between a visiting health professional and a staff member in the public reception area. We also observed staff updating peoples care records on the computer in the reception area which meant personal and private information could be seen by others. Since the inspection the registered provider has told us that there are plans to build a separate office space to improve the situation and in the meantime has implemented privacy screens on computers to improve the way they maintain confidentiality.
• The above concerns demonstrated a failure to ensure the privacy of a service user, which was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• Staff we spoke with understood the principals of privacy, dignity and independence. One staff member told us, "I make sure that I close bathroom doors and I whisper to people when I ask if they need the toilet." On the subject of confidentiality, a staff member told us, "I only speak to people who need to know and I don't tell people outside of work."

Ensuring people are well treated and supported; equality and diversity:

• People told us that they were cared for by staff who were kind and caring and took the time to get to know them. One person told us, "The care has always been par excellence, they [staff] do anything you want; no complaints."
• We observed people being treated with kindness and observed friendly and positive interactions between the staff and people living at the home.

• People told us that staff were polite and courteous, one person told us, "If they [staff] weren't polite we'd give them a mouthful, they are always polite and have made me welcome."

Supporting people to express their views and be involved in making decisions about their care:

• The registered provider facilitated resident's meetings for people living at the home where people were given the opportunity to contribute their thoughts and ideas about the running of the home. Agenda items at the meetings included food menus, laundry, cleanliness, activities and complaints.
• The registered provider sought people's views by asking people living at the home to complete a quarterly survey. Records showed that the results of recent surveys were generally positive.
• The registered provider showed us several online reviews about the home which had been submitted by people using the service and their relatives. The reviews that we saw were very positive about people's experiences of care at the home.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

• Care planning to ensure that people's needs were met was inconsistent. The registered persons had not taken the necessary steps to assess the needs and preferences of two people using the transitional care service. Reviewing care plans to ensure that changes in peoples needs were recorded was also inconsistent. 11 people living at the home had not had their care plans reviewed for approximately three months. Following the inspection, the registered provider evidenced to us that all care plans had been reviewed.
• People we spoke with told us that they were not included and consulted about the content of their care plans, some people told us that they did not know that they had a care plan. The registered manager told us that care plans were written and reviewed by them without the involvement of the people living at the home, they recognised that this was an area that required some improvement.
• The registered provider was using an electronic care planning system which had been in use at the home for approximately 15 months. The registered manager told us that they and senior care staff were not confident using the software and this was the root cause of the poor care planning at the home. Following the inspection, the registered provider told us that they would provide more training for the registered manager and care staff.
• The above concerns demonstrated a failure to ensure that the care and treatment of service users was appropriate, was meeting their needs and was reflecting their preferences, which was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• People told us that they enjoyed taking part in activities at the home, one person told us, "There are skittles and jigsaws, we play lots of games and sometimes get our nails painted." Another person told us that before they moved into the home they were actively involved with the local church for over 70 years and that the staff supported them to arrange visits from the local vicar.

Improving care quality in response to complaints or concerns:

• The registered provider had only received one complaint in the previous 12 months. The complaint was fully investigated and responded to in line with the organisational policy.
• People were provided with a copy of the complaints procedure in the service user guide and were aware of how to complain if they were unhappy. One person told us, "If I have a problem I talk to [the registered manager]" Another person told us, "I haven't needed to make a complaint, but we would go and see [the registered manager] if we needed to."
• Informal complaints were responded to promptly, one person told us, "There was a problem with the hot water tap, it never got warm. The plumber came out and fixed it, that has been my only problem."

End of life care and support:

• At the time of the inspection no one was at the end stage of their life. However, the registered manager told us that they have previously worked closely with medical professionals and partner agencies when people are reaching the end of their life.
• Staff had recently received training regarding providing 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

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.

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

• At our previous inspection on 11 August 2017 we identified breaches of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The problems we identified during the inspection on 11 August 2017 included the prevention of avoidable harm, the management of medicines, the completion of recruitment checks and completing robust quality checks. We found at this inspection that the registered provider had not acted to ensure that shortfalls were rectified.
• Systems and processes to monitor the safety and quality of the service were ineffective and did not identify significant shortfalls. For example, at the time of the inspection visit monthly care plan audits had not been completed by the registered manager for approximately eight months. The shortfall had not been addressed by the operations manager. Failing to complete audits and checks had resulted in care plans not being implemented and reviewed and people were at risk of avoidable harm.
• Several internal medicines and health and safety audits had been undertaken during the previous 12 months. However, they had not identified that there were no protocols in place for the safe administration of medicines on an 'as needed' basis. Nor had they identified the safety issues related to the risk of burns and scalds due to insufficient radiator protection, despite this being identified at the previous inspection on 11 August 2017.
• The registered manager told us that audits and checks should be undertaken monthly. Records we saw during the inspection indicated that audit checks of infection control, medicines and health and safety were taking place on average every two months. Records showed that shortfalls identified often would not be given timescales for action.
• The registered provider did not have sufficient oversight of the shortfalls at the home. The registered manager told us that they had spent some time providing help and support to another residential home owned by the same registered provider. We were concerned that this was during a time where safety issues were not being identified due to a lack of auditing and checking by the registered manager.
• The above concerns demonstrated a failure to ensure effective systems and processes were established to monitor and assess the quality and safety of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Continuous learning and improving care:

• The registered provider did not adopt a culture of continuous learning to improve care. We were concerned that problems had been identified with the electronic care planning system when we inspected another

residential care home owned by the same registered provider in May 2018. Despite the lessons learned from this shortfall being shared in emails and meetings known problems regarding the registered managers competence using the electronic care planning system were not acted upon.
• The registered manager had not received the support they had asked for to ensure that they could carry out their role effectively. The registered manager told us that they had asked the registered provider for further training and support to help them better understand the electronic care management system, but this was not provided.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:

• There was a notice board in the reception area of the home, which contained information about the home such as the food hygiene rating and CQC registration certificates and the previous inspection rating and report. The display of the rating is a legal requirement, to inform people who use the service and those seeking information about the service of our judgments. The registered provider had also displayed their rating on their website.
• There was a friendly and welcoming atmosphere to the home. During the inspection we saw visitors such as relatives and visiting health professionals. We observed staff engaging with them in a polite, friendly and professional manner.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:

• Team meetings did not take place regularly, staff told us that they did not mind this because day to day communication between the team and the registered manager was good.
• Staff told us that there was a positive team culture. One staff member told us, "Staff morale is good, there is a very good team spirit; we all help each other out."
• Staff spoke positively about the registered manager and said that they were approachable and supportive. One staff member told us, "[The registered manager] is absolutely fantastic, she listens to us, if we had any problems she would sort it out."

Working in partnership with others:

• Feedback we received from health and social care professionals prior to the inspection visit was positive and described good working relationships with the registered manager.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure that the care and treatment of service users was appropriate, was meeting their needs and was reflecting their preferences

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to ensure the privacy of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider failed to ensure that recruitment procedures were established and operated effectively

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 registered provider had failed to ensure that timely care planning had taken place to ensure the health, safety and welfare of service users. The registered provider had failed to assess the risks to the health and safety of service users. The registered provider had failed to ensure the proper and safe management of medicines. The registered provider had failed to ensure that the premises are safe to use for their intended purpose

The enforcement action we took:

1.The registered provider must not admit any service users to the intermediary transitional care service without the prior written permission of the Care Quality Commission.

2.Each month the registered provider must send to the Care Quality Commission a written report in relation to their progress against the action plan submitted to us. The report must identify the progress made in relation to the key risks to service users and should provide a narrative about how each risk is being managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure effective systems and processes were established to monitor and assess the quality and safety of the service.

The enforcement action we took:

1.The registered provider must not admit any service users to the intermediary transitional care service without the prior written permission of the Care Quality Commission.

2.Each month the registered provider must send to the Care Quality Commission a written report in relation to their progress against the action plan submitted to us. The report must identify the progress

made in relation to the key risks to service users and should provide a narrative about how each risk is being managed.