GCH (Peregrine House) Limited

Peregrine House

Inspection report

350 Hermitage Road
Tottenham
London
N15 5RE
Tel: 020 8800 5484
Website: www.goldcarehomes.com

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place on 15 December 2014 and was unannounced. The service met the regulations we inspected at their last inspection which took place on 22 May 2013.

Peregrine House is a care home providing residential care to 35 adults. The home is arranged over two floors and divided into four units. There are a range of people living in the home. Some are older people, over the age of 65, there are younger adults who have physical disabilities and also people with mental health needs.

There is a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

Risks to people were identified under each section of their care plan and included instructions for staff to mitigate the risk. However, we found that risk reviews were not always effective in managing the risk or guiding staff in how to reduce the risk.

We also noted inconsistencies in the recording of medicines given to people and record charts did not record whether additional medicines such mouth washes, pain relieving gels and other prescribed creams had been used or not.

Therefore the provider was not meeting the requirement of the law in relation to meeting people's individual care needs and the safe dispensing of medicines. You can see what action we told the provider to take at the back of the full version of the report.

People told us they enjoyed living at the home and we also received positive feedback from relatives that we spoke with during our inspection. All rooms at the home were for single occupancy and had en-suite WC facilities. There were also some quiet communal areas at the home where people were able to sit with their relatives if they wanted to. Some areas of the home required modernising; the provider was aware of this and showed us an action plan for some planned maintenance work.

People told us staff were kind and they had no concerns about their own safety. Staff spent time with some of the residents doing individual activities. People were seen taking part in Bingo whilst others went to a see a play at a local school. In other cases, we saw that staff did not always ask people for their consent before they supporting them with personal care tasks.

The provider followed robust recruitment procedures before employing staff including references and criminal record checks. We saw that staff were given induction and ongoing training to enable them to perform their duties.

Although staff were positive about the training they received and confirmed that they received regular supervision, we received mixed feedback about how well supported they felt. Some staff said they did not always feel valued by the provider.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). We saw evidence that best interests assessors had visited the service to carry out an assessment to decide whether a person was being deprived of their liberty. The provider had requested authorisation from the appropriate bodies which meant that decisions were taken in people's best interest.

People said they were happy with the food prepared at the home. Relatives we spoke with told us they sometimes ate lunch with their family member. We saw that meat and vegetarian options were available and a variety of soups and sandwiches were also on offer if people did not feel like eating anything from the main options. People with specific dietary requirements had their needs recorded and met by the provider.

People had their health needs monitored. There were regular reviews of people's health and there was evidence that the home responded to changes in people's needs. People told us they went to see their GP on a regular basis.

The manager was approachable and was seen speaking to people and relatives during the inspection. A number of audits were carried out at the home to monitor the quality of service. These included health and safety and food hygiene audits. There was some external scrutiny of the service from the local Clinical Commissioning Group (CCG) through medicines audits and a monthly incident report which the provider sent to them.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Although risk assessments for people were completed, we found it was not always clear how effective risk management techniques were.

Some people were at risk of not receiving medication in the prescribed manner because the instructions for staff were not always clear.

Staffing levels at the home were sufficient, although they were stretched at certain times of the day for example during lunch.

Staff showed a good understanding of safeguarding and were able to describe the various types of abuse that people could be vulnerable to.

Is the service effective?

Good

The service was effective. Security and identity checks were carried out before staff started employment. They received regular training and supervision.

The provider met the requirements of the Mental capacity Act (MCA) and took into consideration people's best interests if they were being deprived of their liberty.

People and their relatives told us they enjoyed the food at the home and were given sufficient amounts to eat and drink.

People had their healthcare needs met and were reviewed by a GP. They also had access to a dentist and optician if needed.

Is the service caring?

Good

The service was caring.

We saw some good examples of caring attitude of staff.

Care plans contained a history of people's lives and recorded their preferences so that staff had relevant information available to them.

People had their cultural needs met.

Is the service responsive?

Requires Improvement

The service was not always responsive to the needs of people.

People were given an opportunity to visit the home and assessments were completed before they came to live at home to see if their needs could be met by the service.

We found that there were inconsistencies with some of the information contained in the care records.

Summary of findings

Although residents meetings were held and people were able to raise formal complaints, concerns were not always followed up.	
Is the service well-led? The service was well- led. The manager was hands on and made herself available to staff and people during the day. A number of audits were carried out at the home, although action points were not always followed up. The provider had identified a number of areas of improvement and showed us some action plans related to these.	**Requires Improvement** 

Peregrine House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 December 2014 and was unannounced. The inspection was carried out by two inspectors.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service and safeguarding alerts raised. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with five people using the service, three relatives, ten care workers, and other staff members including a handyman and kitchen staff. We also spoke with the registered manager and the regional manager. We looked at records, including eight care records, six staff files which included training records, nine medication records, audits and complaints. During our inspection we observed how the staff interacted with people who used the service. We looked at how people were supported during their lunch. We 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.

Requires Improvement

Is the service safe?

Our findings

Risks to people were identified under each section of their care plan. Risks identified included guidance to staff on how to minimise the risks. For example, one person was said to be at risk of choking and guidance included ensuring foods were pureed and thickeners were added to drinks. However, we found that in some cases, risk reviews failed to indicate how effective the actions were in managing the risk. For example, one person's care plan in which a risk of pressure sores was identified, the monthly review of the risk gave no indication as to the condition of a person's skin. It only instructed staff to continue with the actions. In another record where the risk of pressure sores was identified, no instructions were set out for staff concerning how the risk for this person was to be managed. In another example where the risk of losing the ability to stand was identified, staff were required to use a rota stand as the preferred means of supporting the person. The review gave no indication of whether this had been effective. We saw that risks identified in respect of depression carried no identified actions. Smoking in bed was identified as a fire risk for a number of people on medication which made them drowsy. The actions required of staff, which were to ensure bins were emptied, were not adequate to address this risk.

These examples demonstrated that there was a potential risk that people may not have been receiving care that met their individual needs. This is a breach of Regulation 9, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We noted inconsistencies in the signing out of medicines given to people. In one case, staff had consistently signed to say that a vitamin supplement had been given twice a day when the instructions said that this was to be given only once a day. Another person was prescribed one to two tablets of a particularly medicine per day. Their Medicine Administration Record (MAR) chart was not clear whether one or two tablets were given. In addition, we noted that in many incidents the MAR did not record whether additional mouth washes, pain relieving gels and other creams we saw prescribed had been applied or not.

We noted that many of the recommendations of a medicines review undertaken by the local Clinical Commissioning Group (CCG) had been enacted although some had not. For example, the report noted concern about the lack of instructions for staff about the application of creams and the lack of recording around this issue.

We also had concerns about the timeliness of giving people their medicine. For example two people needed to have a particular medicine 30 minutes before their main medicine which did not happen on the day of our visit. Others were to have their medicines with meals. We noted that breakfast for some people extended to 11.30am with lunch starting at 12.30pm. It was not clear how staff ensured medicines were given as prescribed taking account of when people ate.

We concluded medicine management in the home was not safe. This is a breach of Regulation 13, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One person's MAR recorded that they refused their medicines each day. We asked about this and were told that the person had refused the medicine for four months and this had been reported to the doctor. We were shown documentation that confirmed the person's doctor was aware of this.

We spoke with two staff members who were authorised to give out medicines and observed one member of staff giving out medicines. Staff showed us the procedures for managing and storing medicines and the auditing and checking processes in place. There was a clear list of names of staff who were authorised to give out medicines along with their initials. This meant that the staff member signing people's MAR charts could easily be identified.

When medicines were received, one member of staff signed to confirm the amount of medicines received although we noted, and the staff member we spoke to confirmed, that the contents of individual blister packs were not checked.

We saw that the medicines for all the people living at the home were stored in a locked trolley which was kept in a locked room. Medicines that required storage at low temperatures were kept in a fridge in this room and the temperature of the fridge was monitored. We checked the dates of medicines stored in the trolley and in the fridge and saw that all were in date. This meant that medicines were stored safely.

Requires Improvement

Is the service safe?

Controlled drugs were also stored separately in a locked cabinet in a locked room. We saw a list of people authorised to give out controlled medicines which showed that that two people were required to be present when these medicines were given out. The records we looked at showed that two people had signed the MAR chart for these medicines. We checked the amounts of medicine in the cabinet against the records of medicines given out and saw all the medicine was properly accounted for. This showed that controlled drugs were stored and given out safely.

We looked at the MAR charts for nine people living at the home. All the MAR charts contained a photograph of the person the medicine was for. Although, some MAR charts gave information about particular needs in respect of how medication should be given. There were no instructions about how or when prescribed medicines such as mouth washes and creams were to be given. Staff told us that individual arrangements were explained to all staff administering medicines and these additional medicines were delivered with the person's personal care when they were supported to get up or go to bed.

We asked staff about the audit and checking procedures used and were told that this was undertaken by night staff and that monthly audits were undertaken. We were shown the report of a medicine review recently undertaken in September 2014 by the CCG. This was welcomed by the manager as a means of providing independent scrutiny of medicines.

People we spoke with during the inspection did not raise any concerns about their safety. We spoke to staff about their understanding of safeguarding. All were able to describe the various types of abuse that people could be vulnerable to, including the risk of neglect, emotional or physical abuse. Staff confirmed that they had received safeguarding training adults and that this training was updated annually. One person said, "We do it every year." Staff were aware of the providers policy concerning reporting of any potential safeguarding issues and the location of both the provider's policy on this and the posters in the main reception which summarised the policy. Staff were clear about the need to report concerns to external agencies if necessary and that the provider had a whistle blowing email address which could be used if necessary. This showed that people were safe from the risk of abuse because staff knew the signs of potential abuse and how to raise concerns.

We observed staffing levels at the home. There were two shifts during the day, from 07.15 to 15:00 and 13:45 to 21.30 supported by 'floating' care workers working between the hours of 08:00 to 13:00 and 17:00 to 21:00.

The provider allocated one care worker to support people on each of four units. There was an additional two care workers during the mornings and evenings to support these staff. We saw that this number of staff were on duty on the day of our visit. In addition to this, manager and deputy manager were available to support and assist care workers and activity co-ordinators and additional cleaning and administrative staff. There were three waking night staff.

Staff told us that most of the people living at the home required support with their personal care and that some required support from two members of staff particularly due to the need to use hoists. We tested response times to three call bells and saw staff were able to respond in reasonable times. Staff confirmed that the manager and deputy manager supported carers when required. Our observation of lunch showed that there were enough people to support those needing assistance with food. However there were indications that staff were stretched. For example people expecting lunch at 12.30 were still waiting to be served at 13:00. We also noted that people were left at their tables long after the meal had ended. We observed three people who needed support to move had fallen asleep at their tables.

Good

Is the service effective?

Our findings

Prior to starting employment, photographic identification had been obtained for each member of staff, job applications forms completed and two independent references had been obtained for each. We saw that Disclosure and Barring Service (DBS) checks had been undertaken for each staff member. We spoke to five members of staff who confirmed that DBS checks had to be completed before they were allowed to start work. This showed that the provider recruited suitable staff to work at the home.

We saw that staff were given training to enable them to perform their role. Staff told us about their induction and we were shown a training matrix maintained by the manager of the home setting out a wide range of mandatory training including safeguarding, first aid, manual handling, fire safety, managing challenging behaviour, health and safety, Mental Capacity Act (MCA) and medicines management. The dates on which staff had completed their training were recorded. The staff records we looked at showed that staff had undertaken this training as certificates for each course were filed. Staff told us that certain aspects of their training were regularly updated including topics such as safeguarding.

We spoke to four staff about the training they received. They were able to describe their training and felt that the training provided was helpful and informative. One staff member said “The training is very good; we cover a wide range of topics. Safeguarding is done every year.”

Staff also told us about the supervision and appraisal system in operation at the home. Staff said they felt well supported and that supervision was helpful. One person said, “We have regular supervision and annual appraisal. It’s an opportunity to think about your work and bring up any problems.” The staff files we looked at contained records showing that staff received regular supervision and annual appraisal.

This showed that people were cared for by staff who were suitable to undertake their work and who were trained and supported in carrying out their duties.

Although we saw that people were able to give their preferences and had these preferences recorded, during the inspection we observed that staff did not always ask people for their consent before supporting them. For example, we saw staff giving one person their eye drops without asking them if they could do this first and giving another person their medicines on a spoon, again without explaining what they were doing.

Each person had a ‘choice form’, in which their preferences regarding hygiene, dressing, smoking, and breakfast was taken into consideration. People had also signed consent forms for the administration of medicines, care plans to be read by health professionals and for their photographs to be taken.

Staff had attended training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and were aware of the need to balance the rights of people to have freedom against the need to keep them safe. A DoLS poster was on display which gave staff a quick snapshot of what may constitute a deprivation of someone’s liberty and what steps to take.

The provider was meeting the requirements of the MCA and DoLS, we saw evidence that best interests assessors had visited the service to carry out an assessment to decide whether a person was being deprived of their liberty and if so, if it was in the best interests of the person. The provider had submitted applications to the local authority where it was decided a person was being deprived of their liberty and it was deemed that this person did not have the capacity to understand the reason why this decision was being taken. There was evidence that a best interest meeting had been held to ensure that any decision taken was in the best interest of the person.

People said they were happy with the food prepared at the home. Some comments included, “The food is nice”, “It’s tasty”, “It’s very nice” and “I like the food.” Relatives that we spoke with told us they sometimes ate lunch with their family member and it was “good quality, really tasty.” We observed staff preparing food in the kitchen, which was clean.

The menu was on display in the communal areas. We saw that there was a meat and a vegetarian option available. A variety of soups and sandwiches were also on offer if people did not feel like eating anything from the main options. Our observations during lunch were that people were given time to finish food.

People that had allergies or were diabetic had their needs clearly recorded in the kitchen and kitchen staff were aware of their needs. Each unit had its own diary kept in the

Good

Is the service effective?

kitchen in which the choices of each person were recorded. Fridge and freezer temperatures were recorded and food stored was labelled with the date it had been opened and when it was to be used by.

People had their health needs monitored. There were regular reviews of people's health and there was evidence that the home responded to changes in people's needs. People told us they went to see their GP on a regular basis. One person said, "There is a doctor down the road." Relatives also told us they had no concerns about how the home managed people's health and were satisfied that appropriate referrals were made.

The care records showed that people had access to healthcare professionals if required. For example, we saw that a person had lost some weight over a period of time so appointments had been made for them to be reviewed by their GP. Also, referral to the falls clinic had been made following a number of falls for another person. People had medicine reviews every six months. People also had access to a visiting chiropodist and a community dentist if required. Records showed that people were able to see an optician.

Good

Is the service caring?

Our findings

People using the service told us that they liked living at the home. Some of their comments included, “it’s okay, it’s nice” and “I’m fine, staff are very nice, very helpful.” Relatives also praised the caring attitude of staff and said “I have no complaints about the staff here”, “they are great, very caring”, and “I visit often and have never seen anything untoward.”

Care records had details of people’s social history and likes and staff had good knowledge of the people they cared for, their personal preferences and their interests. We saw some good examples of the caring attitude of staff, including a staff member helping a person to wrap some Christmas presents for their family. However, we also saw people spending time sitting in the communal area or in their own rooms with limited meaningful interaction with people.

People told us they were able to have visitors come and visit them at the home which we saw during the inspection. One person said, “My sister comes and visits me.” Relatives also told us they were able to come and visit and were made to feel welcome by staff.

A list of key workers was on display in the lounge. Some people that we spoke with were aware of their key worker whereas others were not. We received mixed feedback from staff about the purpose and effectiveness of the key worker system. Some said it helped to foster caring relationships whereas others felt that there was no difference in the role of an allocated keyworker and a care worker.

Residents meetings were held regularly by the service and the minutes from previous meetings were on display in the home. We saw that people were able to raise issues that they felt were important to them.

People’s privacy was respected. All rooms at the home were for single occupancy and had en-suite WC facilities. Although some of the bedrooms that we saw were quite basic in the way they had been furnished, others had been personalised with people’s belongings, such as photographs and ornaments. There were also some quiet communal areas at the home where people were able to sit with their relatives if they wanted to. A number of people smoked. Staff had difficulty ensuring they only smoked in the designated areas and not in their bedrooms. We saw people using empty drink cans and ashtrays in their rooms and the smell of smoke was very apparent in some areas of the home.

People also told us that their right to have as much independence as possible was respected by staff. They told us, “I go out alone” and “I have a shower by myself.” People’s cultural needs were respected by staff, for example respecting their wishes and providing male care workers where requested. Where people had preferences in terms of how they wanted their personal care needs to be carried out, their wishes were met by staff.

Requires Improvement

Is the service responsive?

Our findings

The provider carried out assessments on people before they came to use the service to see if they were a suitable placement for the environment and that their needs could be met. People were given the opportunity to come and visit the service and if they wished to stay overnight to get a feel of the place before deciding. Once people had chosen to live at the home, a six week review was held which was attended by a social worker to see if people were satisfied with the care and treatment they had received. We looked at some pre-admission assessments that had been carried out for people and saw that areas such as medication, personal care, communication, sleep patterns, cultural and religious needs and interests were looked into and a judgement made based on this to see if people's s needs could be met.

We found that there were inconsistencies with some of the information contained in the care records. Some of the care files we reviewed contained pre and post admission assessments which informed a person's care plan. Others contained little information about the reasons for admission or the aims of a person's stay at home.

Care plans contained in the summary sheet information related to communication, eating and drinking and personal hygiene, Medicines, social activity and their preferred time to go to bed. These were reviewed every month. In some sections of the care records, we had difficulty ascertaining whether actions identified were carried out. For example, one person at risk of dehydration required staff to monitor fluid in intake and output and to ensure regular changing of catheters. It was very difficult to see from the person's record whether or not these actions were undertaken. An 'at a glance' chart had been used for a few months previously but current references to these actions were subsequently contained in the day notes. The day notes has been removed from the care file and when located by staff were difficult to read.

The manager told us and we saw that elderly and frail people were living in the same units as people with mental health conditions and younger people with relatively limited disability. This mix impacted on the ability of the service to provide a service that was responsive to the needs of individuals. One person had suffered brain damage as a result of a stroke. Staff reported having successfully helped this person to travel abroad to visit family. However this person's day-to-day life independence and autonomy was limited. Care plans did not focus on achievable aims or goals. For example, the ability to make a cup of tea or cook their own food was not possible in this home due to the fact that the all meals were provided for people and supporting this person to maintain their independence may not have been possible.

An annual activities planner was on display in the home along with a plan for the month. We spoke with the activities coordinator who told us they tried to do a mixture of individual and group activities. We spent some time observing bingo being played at the home and saw that people were encouraged to take part. On the day of our inspection some people were supported to visit a local school to watch a children's play being performed.

Resident's meetings were held every four to six weeks and areas such as menu, activities, and complaints were discussed. It was difficult to see if actions resulting from meetings were followed up by staff. For example, people had asked for certain activities, and made suggestions about food but it was not clear if the service responded to these suggestions and if actions were assigned to staff to follow up. The minutes of subsequent meetings did not record whether these suggestions had been acted upon.

The service user guide contained information on how to make a complaint. A simple flow chart explaining the complaints process included key contact details, accessible to the majority of people was displayed within the home. The complaints policy gave details of how people could escalate a complaint if they were unhappy with how it had been dealt with by the manager.

Relatives we spoke with told us that they had not raised any formal complaints but were able to raise some suggestions and improvements which the manager considered and took on board. When formal complaints were raised, the provider had taken action in responding to people's concerns.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post at the time of our inspection. They had been employed by the service since 1998. During the inspection we spoke with the registered manager, who was familiar with the needs of the people using the service and staff which indicated that they were actively involved in the running of the home. The provider met legal requirements, including conditions of registration from CQC, such as notifications of incidents that occurred at the home.

The registered manager was supported by a staff team with delegated roles. There was a deputy manager and three senior care workers also known as duty officers and care workers. In addition, there were two part time activity co-ordinators and other ancillary staff such as a kitchen team, domestic staff, laundry/housekeepers and a handyman. This allowed duties to be split up, staff told us that this helped them to perform their roles effectively.

The manager told us she had an open door policy and tried to make herself as accessible as possible to people and staff. We observed the registered manager talking to residents throughout the day in a friendly was and spending time with them which demonstrated an open and inclusive way of working. People that we spoke with and their relatives told us that the manager was, "Lovely", "Always available to speak with", and "Very kind."

Staff meetings were held regularly, these included daily handovers between day and night staff and formal staff meetings held monthly. The minutes from the staff meetings gave the impression of a lack of two way conversation between the manager and staff. We spoke with the manager about this who reassured us that meetings were an open discussion, and the minutes were not an accurate record. However, this was not always backed up in the conversations we had with staff. Some staff said that they felt well supported whilst others said that the support could be better and teamwork between staff could be improved. Some of the comments were "Not really well supported", "Sometimes do not feel valued", "I've been told we cannot contact head office directly, have to go through the manager." Many of the negative comments from staff were around issues to do with salary.

There were a number of audits carried out by the provider. Some of these were carried out by the registered manager or the deputy manager whereas others were done by a member of the regional team or from professionals outside the organisation. For example, a nutrition audit was carried out every month. A kitchen audit, a health and safety and an infection control audit had recently been completed. A home audit looking at the home environment was completed by a regional manager and action points were assigned to staff to follow up. We also saw that a medicines management audit completed by the CCG and that no major issues had been identified although there were a few recommendations for staff to follow.

We saw that in some instances, the provider took action based on any issues that were picked up. For example, if a change in a person's weight was identified during the nutrition audit, a referral were made to their GP. In other examples, it was not clear how feedback was acted upon. For example, a resident satisfaction survey took place in June. The registered manager told us that these were followed up in staff and resident meetings; however this was not always reflected in the minutes that we saw.

Every month, the provider sent a report to the CCG providing a breakdown of how many incidents related to clinical care, acute care, risk management and medicines had occurred. Some examples of reportable incidents included the number of pressure ulcers, falls, admissions to hospital, safeguarding alerts and complaints. We looked at the monthly breakdown since January 2014 and saw that the number of incidents was low. This meant that the provider had good oversight into the number and type of incidents which could be used to analyse trends and take action if required.

The provider had identified a number of areas of improvement. These included working towards the Gold Standard Framework (GSF) for End of Life Care. GSF is a systematic, evidence based approach to optimising care for all patients approaching the end of life. This included the registered manager and a care worker attending a workshop for GSF, and working towards gathering evidence related to this.

The registered manager told us they were in the process of revising the way they wrote their care plans to make them more person-centred. We were shown some examples of the new style of pre-admission assessment forms that were awaiting approval by head office. The registered manager was also aware that parts of the home needed updating

Requires Improvement

Is the service well-led?

and we were shown a refurbishment programme which included bathrooms in three units to be refurbished, replacing flooring in some of the bedrooms and redecorating the communal areas on the upper floors.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person did not take proper steps to ensure that service users were protected against the risks of receiving inappropriate care or treatment for their individual needs through the planning and delivery of care. Regulation 9 (1) (b) (i).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not always protected from the risks associated with the dispensing and recording of medicines. Regulation 13.