Four Winds Care Limited

Admiral Court Care Home

Inspection report

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Overall summary

The inspection took place over two days. The first visit was on the 17 December 2014 and was unannounced which meant the provider and staff did not know we were coming. Another visit was made on 19 December 2014.

As this home was registered with a new provider on the 1 December 2014 this was classed as their first inspection. The inspection was carried out because concerns were raised with CQC by several members of the public, and was a response to those concerns. As the service had only been registered for 17 days at the time of our inspection we have not been able to rate the service, instead have focused on the areas for improvement.

Admiral Court Care home is a care home over two floors. The home has the capacity to take up to 50 residents. At the time of the inspection there were 37 residents living there, 17 upstairs and 20 downstairs.

There was a registered manager in place at the time of the inspection. 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.

We were responding to concerns raised with us by members of the public and we concentrated on looking at those issues. Those issues related to the premises, staffing levels and how medicines was administrated. We spent time looking at all areas of the home but have not reported on this as at this time are focusing on the areas that require immediate improvement.

We found that staffing levels were not sufficient to ensure people received care in a safe way. The registered manager told us, they were struggling to get sufficient suitably qualified and prepared staff to meet people's health needs. At times qualified nursing levels were low, with the registered manager having to cover many shifts.

We were unable to examine what training people had received as the previous owner's records were not available and the home did not have a system in place to show what training people had received. We discussed this with the registered manager, and the area manager who recognised this shortfall and were in the process of ensuring that it was put right.

When we arrived on the first day there were no policies or procedures available, to guide staff. By the second day there were policies and procedures in place relating to medicines, fire safety and recruitment and selection but these were not yet available to the staff team.

Staff understood the Mental Capacity Act 2005 for people who lacked capacity to make a decision and Deprivation of Liberty Safeguards to make sure they were not restricted unnecessarily. Relatives confirmed they had

Summary of findings

been involved in the agreements about keeping people safe and that people were able to take "reasonable risks" with support so they had as independent a lifestyle as possible.

We examined the care records for seven people who lived there and noted that these had not been updated for many months. There had been no updating since the new providers took over.

We did see some people needed special support with their diets due to a variety of factors such as being unable to feed themselves or needing help and support during their meals to ensure they ate their food. We saw those people who needed help with feeding receiving appropriate support.

However in at least one case we saw that a person (although we saw they were supported appropriately) were considered at risk because they had difficulty swallowing had no assessment of the potential risks and no written guidance for the staff as to how they should be supported.

In another case where a person could forget to eat we saw very little support to ensure that they continued to eat their meal and little evidence of any effective monitoring of this. In that case the records showed that they had eaten a full meal where we observed they had only eaten one mouthful before the meal was removed.

We examined all of the records relating to medicines. We saw there were records missing and noted that some people received their medicines late which due to the type of medicines could lead a person to suffer from unnecessary pain. We noted one person had no form of communication so could not have articulated if they were in pain or not.

There were other concerns regarding medicines in relation to how well the storage was organised and how peoples changes in medicines was recorded.

We examined the premises. It was clear that the home was in a poor state of up keep prior to being taken over. The new provider had made some changes particularly with regard to the bedrooms upstairs. We saw that the "middle" branch corridor upstairs was closed off and undergoing major transformation. However the current conditions where people were living upstairs were poor.

The lounge and dining areas had been re decorated but the corridors, toilets and bathrooms were in a very poor state. There was heavily embedded dirt in most of the flooring.

One bathroom was locked off as unusable; one bathroom had a patch of bare wood under the toilet which would be difficult to clean properly. This area of bare wood where a new toilet had been fitted also had a three by two inch hole at the back of the toilet underneath the waste pipe. This meant proper cleaning could not be achieved and it held the potential to harbour bacteria and become foul smelling should "any accidents" occur. We noted similar concerns with other bathrooms.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
We identified a number of concerns in relation to medicines, including storage, timing of administration and people not receiving their medicines as instructed.

The home did not have sufficient staff employed to ensure all shifts were covered on a regular basis.

There were a number of concerns in relation to the upkeep of the premises and in particular the safety and cleanliness of the bathrooms.

There were very few records relating to how safely people had been recruited. The manager did not have access to many records relating to recruitment prior to 1 December 2014

Is the service effective?
The home did not know what training people had received and could not tell what tasks people could do effectively and safely.

People's nutritional needs were not being met as the recording of what people ate did not always reflect what they actually ate and support plans for people with eating difficulties were either non-existent or not up to date.

Is the service caring?
We saw staff responding to people's needs. In most instances this was in a caring and polite way. We did observe where some people were treated indifferently; in some cases verbal requests were ignored.

On the first day of the inspection we saw that many people looked as if their hair had not been brushed, or any attention had been given to the clothing they were wearing. By late morning several were still in bed, most seemed as if they had not had their hair brushed or cleaned, and wore a variety of mismatched clothing.

Is the service responsive?
Care planning was out of date with no changes being noted in the seven people's records examined for many months. No updates had been completed since the new provider took over.

Observations showed that staff were reacting to people's daily needs rather than responding in a planned way.

There was a lack of planned organised activity in relation to meeting people's needs.

Is the service well-led?
The registered manager told us there were no policies or procedures in the home on the first of our visits By the second visit there were three policies and procedures in place relating to staffing, fire safety, and medicines.

When we asked for how he checked how the home was meeting people's needs and his auditing processes. We were told that there were no auditing or checking processes in place.

Admiral Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

The Care Quality Commission has decided not to rate this service as at the time of the inspection the new providers had only been operating the home for 17 days.

This inspection took place over two days. The first visit was on the 17 December 2014 and was unannounced which meant the provider and staff did not know we were coming. Another visit was made on 19 December 2014. On that day the provider knew we would return.

The inspection team on 17 December consisted of three inspectors. On the 19 December 2014 the team consisted of one inspector and a specialist advisor who had a nursing background and experience of analysing medicines and health care issues.

During the inspection we examined seven people's care records and examined all of the medicines records for everyone living at the home.

We looked at the recruitment records for six staff who had been recruited since 1 December 2014. We were unable to examine the recruitment records of existing staff as most of these were no longer available to the home when it changed providers.

During this inspection we carried out two observations using 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 communicate with us. We undertook general observations of how staff interacted with people as they went about their work.

We spoke to six staff, the registered manager and the registered provider. We spoke to three people living there and two of their relatives.

Is the service safe?

Our findings

We noted several concerns in relation to medicines. We saw that storage was an issue with no apparent system in place to store medicines in systematic way. This was evident in the cupboard spaces where medicines was stored for later use and in the trolleys. Medicines had been given out at different times each day meaning some people did not receive their medicines at times that matched their needs. We examined the medicines trolleys, we saw that the trolleys were not fit for purpose, medicines was disorganised within the trolleys and there were a number of individual boxes of medicines.

We examined the medicines administration records (MAR) for all people living in the home since the home had been taken over by the new providers on the 1 December 2014. We saw the morning medicines round on 7 December 2014; there were no signatures against any record. This meant we could not tell if people had received their medicines and if they had who had administered it.

During the inspection there was not a signature master sheet for medicines administration available for us to view. This is a record of staff signatures against their names so that it would be easy to discover who had signed for medicines. We asked nursing staff and the registered manager about it and were informed they did not have one. This was important because it meant it would be difficult to determine who had administered medicines if something was wrong or incorrect. Also we were unable to cross reference to the training records of people to ensure they were suitably trained to give out medicines. We asked the registered manager who confirmed it was not present.

We noted that medicines that were required to be refrigerated were kept in the fridge and we saw that temperatures relating to refrigeration had been recorded daily and were between two and eight degrees centigrade. However, we saw that there were no dates of opening on eye drops and eye ointments, which had a shelf life of four weeks from opening. This meant that a pharmaceutical product may no longer be within an acceptable condition to be considered effective.

A member of staff told us, “The medicines is a bit chaotic, some medicines have not been delivered, some medicines are missing and I’ve been unable to find some MAR sheets” and “medicines is a big issue”

We noted poor recording and observed an error in giving out medicines in relation to one persons changed medicines. There had been an increase in medicines and the change was hand written into the MAR chart and did not show who had changed it or why it had been changed. This was dangerous because the change was not reflected in the MAR chart and the person could have received the wrong dose of medicines had they not challenged the person administering the medicines on that day.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inspectors discussed the staffing situation with the manager. He stated he had to cover many shifts himself as it was difficult to get agency nursing cover at short notice. During the inspection visit on 19 December 2014 there was a shortfall in nursing staff meaning the registered manager had to cover the shift. He said he had covered three shifts in the last four days. He also mentioned that the added problem of using agency staff meant that care plans were not getting done as these had to be done or reviewed by permanent nurses who knew the service users.

We spoke to the registered manager about concerns with day to day staffing arrangements. He explained that the home currently had one nurse for night time duties and one nurse for day time duties. He explained that this was not sufficient and they were using agency staff and in the process of recruiting bank staff.

The manager and provider explained that they did not use any assessment tool to determine what would be appropriate levels and skill mix for staffing the home. It was clear during our visits the low levels of nursing cover were having an impact on services. We found that on some day’s people’s medicines were delayed by up to two hours

We examined the staffing rotas since 1 December 2014. This showed that for 13 out of 28 days only one nurse was identified to work. For nine of the days there was no identified nurse on duty so cover had to be provided by a manager from another home or, the registered manager. There were only six days where there was clearly identified nursing staff to provide nursing cover for each floor.

One member of staff told us “It gets busy downstairs and we could do with more staff”, and “We have told the manager about the situation but he has said there is nothing he can do about it.”

Is the service safe?

One relative we spoke to said that her relative appeared "Safe and happy but had only been here 10 weeks". However, they added, there was "Not enough staff, they were not visible, you have to go and find staff", "They let me in, and then don't speak"; "They don't have name badges so you don't know who's who".

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During the inspection we viewed all of the first floor bedrooms, bathrooms and toilets and examined some of the ground floor bedrooms. We noted the handrails in all corridors were worn to the point where several different layers of old paint could be seen.

We noted the flooring in the upper corridor was heavily stained with flaked paint embedded in part throughout its length. It looked dirty and felt "tacky" to walk on and would be very difficult to clean effectively in its current state. We noted the flooring in the three upper toilets were heavily stained with flaked paint embedded in part throughout its length. This also was and felt "tacky" and would be very difficult to clean effectively in its current state. Two toilets needed decorating in order to afford effective cleaning.

We noted that three first floor bedrooms were in urgent need for refurbishment and the provider had "decommissioned" one bedroom as it was unfit to be occupied. We noted that there was a strong smell of urine in the corridor opposite the dining area in the first floor accommodation.

We saw one bathroom and noted the flooring was heavily stained and was dirty at the far end for almost a quarter of the length of the room. This bathroom had stained water on the floor.

In another bathroom the floor heavily stained and dirty. There was bare wood around the base of the toilet and a three by two inch hole at the back of the toilet underneath the waste pipe. This meant proper cleaning could not be achieved and it held the potential to harbour bacteria and become foul smelling should "accidental spillage" occur.

On entering the sluice room we noted it was dirty and smelled of urine and faeces. The sink was stained and dirty as was the floor. The hand washing sink was also dirty. The door was stained as were the walls.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we arrived on the first day we asked to see the policies and procedures within the home. The registered manager told us that there were no policies or procedures in place as the previous owners had removed them the day they left.

By the second day of the inspection we noted there was a limited number of policies and procedures available (medication, recruitment and fire guidance). This was of concern because it meant there was insufficient information to guide staff about what is expected of them when caring for people and keeping them safe.

We discussed safeguarding issues with one staff member who told us what was expected if they should suspect abuse or had concerns. They said they knew that they could "approach the local authority directly if the concern was serious or related to the running of the home or if they thought the home was not taking a concern seriously".

The lack of any procedures meant that none of the newly recruited staff had received any guidance about safeguarding adults. They did not have any access to policies and procedures relating to safeguarding which would form an essential part of their training in that.

Another member of staff said, "We have safeguarding and whistle-blowing policies, I've worked with local authority safeguarding." "Incidents are recorded in the file and held on the service users file" and if they suspected or witnessed abuse they "would speak to the manager, talk to local authority and tell the family".

Another staff member told us, "Report it always to the management and get it recorded". This showed us the staff member knew what to do in the case of suspected or witnessed abuse.

Personal risk assessments were either not in place or had not been renewed for several months. Of the seven people's records we examined no risk assessments had been updated since April 2014. This meant that care plans and risk assessments were not current and staff would find it difficult to gain suitable guidance about a person's care by reading them. This was particularly relevant to the health and medicines sections of the care records where changes to medicines had not been recorded.

We viewed three files for staff who were employed in the home prior to 1 December 2014 and still worked there. In two of those files there was no record of any Disclosure and

Is the service safe?

Barring Service (DBS) check and the other showed that the last recorded date of checking was 22 June 2008 when they first came to work in the home six years previously. DBS checks ensure that only suitable people are employed by the service, which should help to protect vulnerable people against the risks of unsuitable staff.

We also examined six records for staff newly recruited since that date. All, of those who had commenced work (four) had relevant safeguarding checks in place including identity checks, DBS checks, previous work histories, and references. The other two showed the home was in the process of acquiring that information prior to starting work.

Is the service effective?

Our findings

We asked to examine the training records for staff. We were told there were no training records available as these were held electronically by the previous providers and no longer accessible since the new provider had took over on 1 December 2014. The area manager told us that they had identified some key shortfalls so were introducing some catch up training in key areas such as moving and handling, first aid and safeguarding etc. One member of staff told us " We have not had any training for a long time"

This was deemed to be unsafe because it meant the manager did not know which staff could use hoisting and lifting equipment safely, were trained to give out medicines, knew what to do in case of fire or suspicions of abuse, how to move and handle people when assisting them to move around, stand up or get dressed etc.

We examined six staff records. There were no records of supervisions taking place in the time the home had been registered with the new provider. The records prior to this were not available.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Although out of date some care records showed that some people needed support to ensure they maintained a nutritious diet. We examined one person's record where it stated they needed support when eating to ensure they ate their meal. During a meal time observation we saw minimal encouragement for this person to eat their food. Two staff asked them to eat up as they passed but at no time did anyone give a concerted effort to encourage them. We noted the staff observation of this meal time stated that they had their full meal and pudding. This was incorrect as the inspectors observed that they ate only two mouthfuls of his main course and one of their puddings.

We also saw that some people needed support in eating. We saw one person receiving one to one support whilst eating his solid food.

We saw some records where people had difficulty with nutrition where their weight needed to be monitored. We noted there was some recording of people's weights but this was inconsistent across all records.

During another observation of a meal time we saw that the tables were not set, had a cover on top of the table cloth, and staff handed cutlery when people were seated. We saw one person walked over to counter repeatedly asking for food but not receiving any and where another person had their food cut up without being asked about it or informed about it.

We saw one person had a bib put on. That person was not asked if they wished to have a bib, it was given without choice. Staff wiped that person's mouth without asking or advising what they were going to do.

We saw one person was left to eat food at the table there was no interaction with staff, when they were present the meal time was task driven with no communication. We saw staff clear the table when people had not finished their meals

There were no choices of food; people were asked "do you want mince and dumplings?", "Do you want a pudding?", When we asked a member of staff about this we were told "if a person doesn't like what's on offer the cook will make them something else".

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS), and to report on what we find.

Staff understood the recent court decision about DoLS to make sure people were not restricted unnecessarily, unless it was in their best interests. The registered manager had made DoLS applications to the respective local authorities that were involved in each person's placement.

The registered manager understood his obligations in relation to DoLS and because of difficulties accessing previous staff training records stated that he intended to ensure that staff received suitable training in the near future. He said this had not been programmed yet as they were prioritising key training in other areas.

We saw records showing where people's mental capacity had been assessed. Some of those were complete but in one record we saw that the first part which assessed if people needed a full capacity assessment was completed but the full assessment was blank and those documents dated back to June 2014.

Is the service caring?

Our findings

We spoke to one person who told us "the staff are very kind and try to do what they can for you but always seem to be very busy".

We saw several instances where staff showed knowledge of people's needs. When we spoke to a member of staff and asked them how they knew what care someone needed we were told that they "had worked in the home a long time and knew what care people needed from experience"

They also mentioned that there were care plans for everyone and they could read those but mentioned that "they haven't been updated for a long time".

One staff member, told us, "What's happened here, it's changed so much, it's more chaotic this morning, a bit of this a bit of that, so disorganised". "The staff handover this morning was okay, but I had to ask questions, there's gaps in the care files".

On 17 December 2014 we noted that some people were still receiving their morning personal care at 11am even though it was clear they had been awake some time as we had seen two people walking around for at least an hour prior to receiving care and changes of night time clothing. People were in varying states of dress and many looked as though they had not bathed for some time. We saw one person walking around with a shirt top on and pyjama bottoms at 12 noon. We saw another person walking around with their trousers inside out for two hours.

We were aware that there had been a new admission two days prior to our first visit. We noted that this person had high levels of need and significant dependencies for care. We noted that there was no care planning documents available. Nor were there any risk assessments, particularly in relation to moving and handling, hoisting, support when feeding, and fire evacuation.

A member of the public had previously alerted us to an incident where a person was inappropriately carried. We asked the registered manager and the provider about this incident and they confirmed it had happened as explained to us by the member of the public. As the incident involved inappropriate moving and handling techniques this had the potential to cause harm to the person.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Another member of staff told us "I look at the body language, gestures dementias service users can have good and bad days so I always try".

During the inspection we observed staff interacting with people living there and responding to their needs. On one occasion we saw a member of staff using distraction techniques to help a person calm down when they became distressed. We saw another occasion where a member of staff gently lead a person away to another area when they were showing signs of getting into conflict with another person living there. This showed good understanding of needs and that staff could vary their approaches depending on how people responded.

We saw another situation where a person had slid down their chair and was uncomfortable. Staff responded by two of them trying to assist her to sit further up in the chair. When this was unsuccessful they quickly got a hoist to lift her gently into a better sitting position

These were seen to be caring actions and showed staff knew the people living there and how best to help them in those situations treating those three people differently in accordance with their needs.

We observed staff being polite and courteous with people living in the home. We saw one person whose care plan stated they needed one to one care receiving it as required and that a member of staff was with them constantly often linked arm in arm as they walked about the building. We saw interactions were positive and people engaged that person verbally offering guidance and asking them about what they wanted to do.

We saw that staff were careful to shut doors when people were receiving personal care affording them dignity even when the person was confused and did not appreciate the need for closing doors behind them. We did notice that one person had a commode that needed emptying in full site of the open doorway and that this remained full for at least an hour and a half.

We saw several interactions where people were offered choices about snacks and drinks, or where they wanted to go or what they wanted to do.

Is the service caring?

On the second day of the inspection the home had organised a carol service with a local clergy providing a service and hymns for people living in the home. People were asked if they wanted to attend and many people did supported by two carers and helpers from the local church.

Is the service responsive?

Our findings

We examined seven peoples care records we noted on one that it was recommended by the occupational therapists that the person should be encouraged to use a walking frame to assist her when she was moving around. We did not see that person with a walking frame to hand. When we spoke to a member of staff about this we were told that the person refused to use frame and "it had been decided not to give her it in case she used it as a weapon". We checked the records and found no risk assessment relating to this or record of any incident where the person had responded negatively to being guided about using a frame or why that decision had been made.

During the two days of inspection seven people's care files were examined. It was noted that there had not been any review of the care documents since May 2014 and no updates had been recorded since the 1 December 2014. This meant that care needs and risk assessment were out of date so it was difficult to see what people's needs were and how the home would meet them.

We spoke to a social worker for one person living in the home. She mentioned that the care plan clearly outlined the need for one person to receive one to one attention at least once per day so that staff could reduce her anxieties about her current situation and her future care provision.

We spoke to that person and she said she "never got one to one attention". The records supported this statement; as we saw there was no record of any one to one time being given by the home.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

There were examples of day to day recording where there was evidence that staff responded to needs such as seeking medical help when they suspected someone had an infection. We also saw records where families had been consulted and informed of events.

The home had a permanent member of staff who organised activities for people living there. We were told that person was unable to attend work and would not be for some time. The provider had appointed a person to temporarily fulfil that role. On the second day of the inspection we spoke briefly with that person (it was her first day) who showed us a weeks' worth of activity programmes. There were a range of activities aimed at meeting the needs of groups of people and individuals on a one to one basis.

There were no records available to us in respect of complaints or any analysis of complaints made. At the time of the inspection there was no complaints policy in place.

Is the service well-led?

Our findings

The registered manager had been in place since the new provider took over on 1 December 2014. He had worked in the home as the registered manager for three months prior to this with the agreement of the previous providers.

He mentioned that he had not started any monitoring or auditing processes and that the home did not have any policies or procedures in place since the previous providers left. We discussed the lack of policies and procedures and we noted that the organisations senior administrator was in the home preparing the documents required. By the second day of the inspection we were shown policies and procedures relating to recruitment, medicines and fire safety.

We saw in the records that staff monitored people's welfare with observations. These were recorded throughout the day. In some cases in accordance with their care plans some people were observed and records made every hour depending on their needs. We examined those records and they showed that staff recorded where people were for example in the lounge, in the bedroom. They did not record what the person was doing and they did not capture any wellbeing type of observation. For example if a person was dozing in a chair, engaged in interactions with other service users or staff or undertaking some activity.

On the first day of the inspection we asked the manager what systems were in place to monitor the care being provided. We were told by that there were no systems in place to monitor the day to day activity of people living in the home or what care was being provided.

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 had not taken sufficient steps to ensure people were protected from the risks of receiving care or treatment that is inappropriate or unsafe.** Regulation 9 (1)(a)(b)(i)(ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place to ensure that staff employed were appropriately trained and supported.** Regulation 23(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The registered person did not have suitable arrangements in place to ensure people were protected from the risks of inadequate nutrition and dehydration.** Regulation 14(1)(a)(b)(c)

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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person had not taken appropriate steps to ensure that sufficient numbers of staff were employed for the purpose of carrying on the regulated activity. Regulation 22

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The registered person had not ensured that people were protected against the risks associated with unsafe or unsuitable premised by appropriate maintenance. Regulation 15(1)(a)(c)

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person did not unsure people were protected from the risks associated with unsafe use and management of medicines. Regulation 13

The enforcement action we took:
Warning Notice