Maria Mallaband Limited

Willowbank Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Willowbank Nursing Home is a nursing home providing personal and nursing care to older people and people with a physical disability. The service can accommodate up to a maximum of 37 people. At the time of our inspection there were 29 people using the service. The nursing home accommodates people in one adapted building with bedrooms on the ground and first floor. The main communal areas are on the ground floor.

People's experience of using this service and what we found
There were examples of safe practice but in general people were not safe. People were at risk of harm because the provider did not always identify or mitigate risks. This included risks relating to people's health and wellbeing, and environmental risks such as fire safety. Medicines were not always managed safely. Accidents and incidents were not always appropriately recorded. The service did not ensure staff had the time to give people the care they needed. Robust recruitment checks were not completed before staff started working at the service.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Systems were in place to safeguard people from abuse and control infection.

Services were not planned in a way that met people's needs. Care plans were not person-centred and did not always guide staff on people's current care needs. People's preferences around end of life care were not known although the service did work closely with palliative care specialists to make sure people had a pain-free and comfortable death. Staff interacted with people in a kind and caring way. They described staff as 'very caring', 'good' and 'courteous'.

There were widespread and significant shortfalls in the way the service was led. Complaints were not dealt with in an open and transparent way. Systems to assess, monitor and improve the service were not effective. The service had failed to respond to organisational risk such as fire safety concerns. There was a lack of effective leadership and management by both the provider and registered manager. The service had a range of systems which gave people opportunities to share their views and receive information. The service worked in partnership with health and social care professionals.

The provider was responsive to the inspection findings and sent information to show they were taking action to address the areas of risk identified at the inspection.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 9 February 2021).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the management of risks to people who used the service, medicines, staffing and complaints. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Willowbank Nursing Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to risk management, staffing, responding to complaints, person-centred care, recruitment of workers, medicines management and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Willowbank Nursing Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by 4 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Willowbank Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Willowbank Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, the local health and care partnership, Healthwatch and professionals who work with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spent time in communal areas observing the care and support provided by staff and visited people in their room. We spoke with 7 people who used the service, 4 relatives and 11 members of staff including representatives of the provider, registered manager, lifestyle co-ordinator, care assistants, care practitioners and nurses. We reviewed a range of records. This included 13 people's care records and multiple people's medicine records. We looked at 3 staff recruitment files. A variety of records relating to the management of the service were reviewed.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure safety was effectively managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Risks to people's health and wellbeing were not always assessed, monitored and managed. This included risks associated with skin integrity, nutrition and moving and handling. Some people did not have appropriate risk assessments in place.
● Several people had wounds, but records indicated they were not receiving appropriate care and treatment. For example, one person had a pressure ulcer which should have been redressed every 3 days. Records showed there were longer gaps between dressing changes and the pressure ulcer had deteriorated.
● Staff had taken photographs of some wounds to help to track progression. However, these were not always appropriate and did not help manage risk. For example, they were dark and did not show the wound.
● Some people were at risk of malnutrition and the service had identified they needed to monitor how much they were eating and drinking. We saw several examples where people had much less to drink than their recommended amount.
● The service was not assessing and managing risks when people moved into the service. Risk assessments were not completed within the recommended timeframes. For example, the provider had guidance which stated some assessments must be completed within 6 hours; we saw the service was not doing this.
● The provider did not properly manage environmental risks. A fire safety assessment from June 2022 identified several high risks and recommended immediate action; these had not been addressed. Several pressure mattresses and cushions showed 'low pressure'; staff said this was an on-going problem and they could not be sure pressure equipment was at the correct setting.

Systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the site visits CQC shared concerns with the local safeguarding authority and fire safety service. The provider was responsive to the inspection findings and sent information to show they were taking action to address the areas of risk identified at the inspection.

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

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

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Learning lessons when things go wrong

● The system for learning lessons was not reliable or robust. The provider did not have an accurate overview of what was happening because accidents and incidents were not always appropriately recorded. For example, one person had sustained a large unexplained bruise. Staff had taken a photograph, but no incident form was completed. When we raised this concern, the management team carried out an investigation into this omission.

● One person had 4 falls in December 2022, but their care records stated they only had 3. A member of the management team explained staff had recorded the accident incorrectly, so it had not been linked to the person on the care recording system. The accident forms for December 2022 had been reviewed but the error had not been picked up.

● The service analysed incidents and accidents to help prevent reoccurrence and identify patterns and trends. However, we noted they were using different categories to record the same type of accident, which meant the analysis did not include all events. The management team explained they had guidance around how to categorise events but acknowledged this was not being consistently followed. They took action to address this.

The lack of effective risk management processes meant people were not protected from harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People were at risk of harm as there were not enough staff to keep them safe. Staff did not respond promptly when people needed care and support. During all three site visit days people were in need of support or visibly distressed, but staff were unaware. Members of the inspection team had to locate staff to assist.

● Staff consistently told us care was rushed and they did not have enough staff to meet people's needs. Staff raised concerns that people's needs were not being met, for example, staff did not have time to support people to bathe and shower, and people were unable to get up when they wanted to. One member of staff said, "We are run off our feet. People can't get out of their room because we don't have time, so they don't get enough interaction with others."

● Some people told us staff were not always available and did not always respond to call bells. One person said, "There aren't enough staff at the moment. They have to use agency quite a lot as there just aren't enough. It takes ages sometimes for them to answer the buzzer and I don't think there's a difference between day, night or weekend I just think they are overall short." Another person said, "They rush in and

out and don't seem to want to know you." We observed at two site visits that people had to wait when they requested support via their call bell. For example, one person waited over 25 minutes.
● We visited one person who was in his bed and they raised concerns about mealtimes. They explained they had their breakfast at 11.00 and soon staff would be bringing their lunch. They said, "How can I eat again after having my breakfast so late." Staff confirmed people sometimes had a late breakfast because of the insufficient staffing arrangements.
● The provider used a tool to help calculate staffing levels which indicated the service had sufficient direct care hours. However, feedback from people who used the service, relatives and staff, and our observations did not support this outcome and evidenced staffing levels were not safe.
● Agency nurses worked at the service on a frequent basis but several had not completed an induction to the service even though this was part of the provider's guidance. There was no evidence agency nurses had completed competency checks around medicines.

There were not enough suitable staff to meet people's needs and keep them safe. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A robust recruitment process was not always followed. Some checks had not been completed before staff started working at the service.
● We reviewed recruitment files for 3 staff working in the home and 2 did not have the full checks in place. Gaps were noted around employment history, references and interview records.

Systems were not in place to ensure staff were recruited safely. This placed people at risk of harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not always managed safely. The service had systems and processes in place for the safe storage, administration, and use of medicines. However, these were not always implemented effectively.
● The service had 2 oxygen cylinders stored in vacant rooms. Oxygen can be a dangerous fire hazard and should be stored securely. These were removed when we brought it to the attention of the registered manager.
● Written guidance was not always in place when people were prescribed medicines to be given 'when required' (PRN). When these were available, they were not always accessible to staff at the point of administration. The registered manager told us they were updating all protocols and were looking to implement a system that would make these available for staff when needed.
● There was no information on the electronic medicine administration record (EMAR) that 1 person was prescribed thickening powder. Staff were recording separately when thickening powder had been added to drinks, but this did not always reflect the recommended amount. This meant we could not be assured the person had received the correct level of thickened fluid.
● The service did not always maintain the 4-hour interval between paracetamol doses for 1 person. The service rectified the EMAR system on the day of the inspection to avoid this happening again

We found no evidence that people had been harmed, however, people were placed at risk of harm by the failure to ensure the safe and proper management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe living at Willowbank Nursing Home. One person told us, "I feel safe here, the

staff look after me. I like to stay in bed. There is not much to do but I am happy. I have my telly and my relative comes regularly. I sleep a lot and like to be in bed." A relative said, "[Name of person] is happy here; he is safe and well cared for. We have no concerns."

● Staff understood safeguarding procedures and had received safeguarding training. They were confident the management team would deal with allegations of abuse appropriately.

● The registered manager confirmed there were no open safeguarding cases at the time of the inspection.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider's approach to visiting met government guidance.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- Care was not planned in a way that met people's needs. We saw several examples in care records where information was not person-centred. For example, sections such as 'My preferences, likes and dislikes' were blank.
- Care plans did not always guide staff on people's current care needs. For example, staff discussed 1 person's needs around the delivery of personal care. None of the information was included in their care plan. Two people's care plan stated they would like weekly showers, but records showed this was not delivered. One person's care records showed they had not had a bath or shower between October 2022 and the inspection.
- Two people had recently moved into the service but did not have care plans to guide staff. One person had been at the service 6 days and the service had not started to develop a care plan with the person. The service had gathered some information about the person's individual needs and circumstances.
- People were not involved in developing their care plan. One person said, "I am not sure about my care plan; I think they do it amongst themselves. I've never had it discussed with me." A relative told us they, "Had to fight hard to sort [name of person's care plan] out" and said, "I just don't understand why they don't follow the care plan."

Care was not planned and delivered in a way to meet people's needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us staff were generally caring although some said they did not know staff well. They described staff as 'very caring', 'good' and 'courteous'. We observed staff were kind and caring when interacting with people.
- People looked well cared for. For example, people's hair was brushed, and their clothes were clean.

End of life care and support

- The service did not engage people in planning their end of life care. At the first site visit we found one person was reaching the end of their life and died soon after. The person did not have any plan in place to make sure the end of life care met their wishes and preferences.
- The support provided after a person's death sometimes lacked care and compassion. A relative raised a concern that their loved one was not made comfortable after death and this had caused upset and distress.
- We visited two rooms where people had recently died. These had not been cleaned or tided. One still had bedding and other items such as used cups and glasses.
- The service had generic end of life care plans. After the first site visit, we received assurance from the

provider that 'end of life care plans for all residents living in the home were being reviewed and updated'. At the second site visit we checked 4 people's care plans. These had been updated on 12 January 2023, but all read the same and there was no personalised information. There was no evidence to show these had been discussed with people who used the service or others who were important to them

People's end of life care was not planned to meet their wishes and preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service managed some areas of end of life care well. They worked closely with other professionals including palliative care specialists to make sure people had a pain-free and comfortable death. One relative told us they had received very good support before and after their relative had died. They said, "Overall, the care here has been amazing, and I wanted you to know."

Improving care quality in response to complaints or concerns
● Complaints were not dealt with in an open and transparent way. Concerns were shared with us before the inspection because the service had not responded to a complaint; this was followed up several times by the family and then by CQC in September and November 2022. During the inspection, we found the service had still not carried out an investigation or completed a complaint response. We received assurance from the provider that they would contact the family and address the complaint as a priority.
● The service maintained a complaint overview record. but this did not make any reference to the above complaint. Two other complaints had not been responded to by the agreed timescales.

The system for receiving, recording, handling and responding to complaints was not always operated effectively. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Systems were in place to meet people's communication needs. People had communication care plans which identified how their communication needs should be met.
● The registered manager said they were planning on presenting information to people in different formats which included introducing pictorial menus and 'show plates' to help aid choice.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● A weekly activity planner had been developed which was used as a guide to help ensure activities were suitable.
● People had opportunities to engage in activities although this was not consistent.
● The service had lifestyle co-ordinators who facilitated group and individual activities. At the first site visit we saw they were effective, offering a group bingo session which people enjoyed and spent time with people on a one to one basis. However, at the second site visit, no lifestyle co-ordinator was on shift and people did not have opportunity to engage in activities. The activity planner stated light exercise and baking were the

daily activities, but these were not offered.

Inadequate

Is the service well-led?

Our findings

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

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

Continuous learning and improving care

At our last inspection the provider had failed to ensure systems were either in place or were robust enough to demonstrate risks were effectively managed and comprehensive records were kept. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Widespread and significant shortfalls were identified at this inspection. There were breaches in relation to risk management, staffing, responding to complaints, person-centred care, recruitment of workers, medicines management and good governance. These issues had not been addressed through the provider's own governance arrangements.
● The service had not responded to organisational risk. A fire risk assessment dated June 2022 identified some immediate actions; a hard wire electrical inspection dated June 2020 stated that work was required because there was a risk circuits could overheat. These had not been addressed. Pressure mattress indicators were faulty and staff confirmed it had been a problem for months, but no action was taken.
● Concerns were raised about the staff response to call bells. We saw this had also been raised as a complaint in September 2022. However, the provider was not monitoring response times until after we raised this with them.
● Quality audits were completed by the service and provider. However, they were not consistently effective in identifying issues and driving improvements. For example, care record audits did not ensure care was planned in a way that met people's needs.

The provider did not ensure robust systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was responsive to the inspection findings and sent information to show they were taking action to address the areas of risk identified at the inspection.

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

regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● There was a lack of effective leadership and management. Systems were ineffective and management oversight was poor.
● Staff did not have access to important information about the people they cared for. The service used an electronic care recording system, but people's personal histories and preferences were incomplete. Assessments and care plans were not always completed when people moved into the service.
● The quality of recording in care records varied. People's care records did not always provide enough information to monitor their health and wellbeing. For example, handover records had important information that had not been included in individual records.
● Guidance was available to help ensure the service delivered safe, quality care, but this was not always adhered to, which placed people at risk of harm. For example, the provider's complaint's procedure and recruitment policy were not consistently followed.
● The service maintained a 'resident at risk register' which identified potential risks to people and included areas such as 'time critical' medications, pressure damage and weight loss. However, it did not ensure people had good outcomes because we found risks to people, including skin integrity and weight loss, were not well managed.

The provider did not ensure systems and processes were in place to assess, monitor and manage risk. The provider did not ensure accurate, complete and contemporaneous records were maintained in relation to the care provided. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Notifications about significant events were submitted to CQC by the provider. These showed the provider took action and reported information to external agencies when required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The service had a range of systems which gave people opportunities to share their views and receive information. The provider completed surveys and a monthly newsletter provided people with information about what was happening. We saw in the home the provider said, in October 2022, they would be reinstating 'resident of the day', which was in response to a relative's survey to achieve 'better communication' The registered manager confirmed this was not yet in place and planned for February 2023.

● The management team organised regular team meetings, handovers and flash meetings. We observed 2 handover sessions, which were well attended, and important information was shared with the staff team. Staff told us the handover sessions were effective.
● Several staff told us the registered manager was supportive and approachable.

Working in partnership with others
● Care records showed the service worked in partnership with health and social care professionals.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not planned and delivered in a way to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The system for receiving, recording, handling and responding to complaints was not always operated effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Systems were not in place to ensure staff were recruited safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to meet people's needs and keep them safe.

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
Treatment of disease, disorder or injury	Systems were not robust enough to demonstrate safety was effectively managed. People were placed at risk of harm by the failure to ensure the safe and proper management of medicines

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems to assess, monitor and improve the service were not sufficiently robust.

The enforcement action we took:

Warning notice