Neva Manor Care Home

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Inspection report

4 Neva Road
Weston Super Mare
Somerset
BS23 1YD

Tel: 01934623413
Website: www.nevamanorcarehome.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Neva Manor Care Home is a residential care home providing personal and nursing care to 12 people aged 65 and over at the time of the inspection. The home can support up to 14 people.

Neva Manor Care Home is located in Weston-Super-Mare. The home provides accommodation across two floors. The first floor is accessible by stairs and a stair lift where there are bedrooms and two communal bathrooms. To the ground floor there are bedrooms, a kitchen, communal lounge, lounge-diner and a communal bathroom. The registered manager's office is located adjacent to the lounge. There is level access to the garden and car parking to the front of the home.

People's experience of using this service and what we found
People were at risk of avoidable harm. Risks were not always identified, and risk assessments did not always include correct and sufficient information to guide staff about how they should keep people safe. Medicines were not managed and stored safely, one person had their prescribed controlled drugs administered incorrectly over a prolonged period. People were not always protected from the spread of infection and the provider could not be assured that sufficient numbers of suitably qualified staff were deployed across the service. The provider was not analysing accidents and incidents as a way of preventing a recurrence. People were at risk of potential abuse because there was no oversight of safeguarding in the service and the provider failed to act when people sustained bruising.

The provider's governance system was not robust and had not been used effectively to identify the shortfalls, errors and omissions we found during our inspection. The provider was not always open and honest with people in the home, telling them they had a cold when they had confirmed Covid-19. Staff, people and relatives were not always engaged with. The provider had not undertaken questionnaires since 2018. Staff, people and professionals said the registered manager was approachable. Staff we spoke with said there was a good team and spoke about people in a person centred way.

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 August 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been sustained and the provider was still in breach of regulations. The service has deteriorated to inadequate.

Why we inspected
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 coronavirus and other infection outbreaks effectively.

The inspection was prompted in part due to concerns identified during the infection prevention control checks, areas of concern identified included staffing levels and infection prevention and control. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

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

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We identified breaches in relation to risk assessment and management, medicines storage and management and infection prevention and control. Further breaches were identified in relation to the lack of oversight of safeguarding and failure to identify potential safeguarding concerns. The provider's systems were not robust or being used effectively to ensure errors, omissions and shortfalls were identified, resulting in a further breach.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Neva Manor Care 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 Care Act 2014.

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 team consisted of three adult social care inspectors, however only two inspectors were present in the home at any one time.

Service and service type
Neva Manor Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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, including information received from healthcare professionals. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We reviewed a range of records. This included five people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed. We spoke with four members of staff including the provider, registered manager, deputy manager, and the chef. We spoke with one professional who was visiting the service.

After the inspection
We spoke with six staff and four relatives. We received feedback from one professional. We made four safeguarding alerts to the local authority safeguarding team. We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection we identified the provider had failed to ensure risks were adequately assessed and managed. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not stored and managed safely.
- One person was administered the incorrect dose of a prescribed controlled drug over a protracted period of time. Medicines checks had not identified the issue immediately and this meant staff continued to administer the incorrect dose. When the error was identified, the provider reported it to the GP and the person was placed on a plan to wean them off the high dosage.
- One person was at risk of receiving ineffective insulin because insulin requiring refrigeration was not stored in accordance with instructions. Records of temperature checks showed the fridge was consistently exceeding the safe temperature range. No actions were taken to rectify this. We spoke with the registered manager about our concerns. They contacted the Pharmacist who advised the insulin should be returned to them and replaced. The registered manager told us they would provide information about changes they had made to prevent a recurrence. We have not yet received that information.
- The same insulin was stored in an unlocked fridge in a communal area that was accessible to people. We spoke with the registered manager who told us they had a lock box for the insulin. However, the insulin was not being stored in the lock box at the time of our inspection and was accessible to people. There was a risk unauthorised people, staff or visitors could access the insulin.
- Protocols for 'as required' (PRN) medicines lacked detailed information to guide staff and were not completed in line with published guidance about best practice. For example, information about symptoms that may indicate the person required their PRN medicines was not recorded. Where people could have multiple doses in 24 hrs, the PRN protocol did not always include information about spacing between doses. This meant people may not receive doses when they needed them and doses may be administered too closely together.
- One person prescribed a blood thinner was at risk of avoidable harm because there was insufficient detailed guidance available for staff. Blood thinners are high risk medicines because they prevent blood clotting as normal. The person did not have a sufficiently detailed care-plan including information such as when and how to seek medical assistance. This meant staff may not know what action to take in an emergency or the level of risk associated with this medicine.

- The provider contacted us after the inspection and told us that, in response to our findings, they had implemented an action plan to improve medicines management in the service. We have not been able to

test the effectiveness of the provider's action plan and we will review this at the next inspection.

Assessing risk, safety monitoring and management

● The provider was not always assessing potential risks to people. When risk assessments were completed, they did not always include sufficiently detailed guidance for staff.

● People were at risk of developing pressure ulcers and existing pressure ulcers were at risk of deteriorating. One person's health declined, meaning they no longer mobilised independently. The person required support from two staff while they remained in bed at all times. A body map showed the same person had previously developed two, "Open wounds…." This meant the person was at increased risk from pressure ulcers. The care-plan was updated with three sentences that lacked sufficient detailed information about the increased risk to the person's skin integrity. There was no formal risk assessment or guidance for staff about how to manage the pressure ulcers and prevent them from worsening.

● Information recorded in care-plans and required to keep people safe was sometimes conflicting. One person required a diet of modified food. The information available to staff identified three different ways to modify the person's food. We spoke with staff who also gave conflicting information about who was receiving a modified diet. This meant the person was at risk of being given incorrectly modified food.

● People were at risk from avoidable harm because their moving and handling assessments did not always include sufficient information and guidance for staff. One person required support from, "0-1" staff to stand. Another person receiving care in bed did not have a sufficiently detailed moving and handling assessment. Instead an entry in their review record stated, "2 x staff have to assist (Person's name) to mobilise at the moment." Assessments we reviewed did not always include information in line with published guidance such as, the exact numbers of staff required for the transfer. Additionally, information about the techniques staff should use when supporting people to mobilise or transfer was not always recorded, even though the form prompted for this information.

● The provider was not following government guidance and assessing people's individual risk in relation to Covid-19. There was no guidance in place for staff about how they could reduce this risk. Comments from staff included, "[I] come in have my temperature taken put on PPE, change shoes, go through to put my work clothes on but [there is] no designated room available and I have to walk through the home to get changed" and, "[I] was not taught how to don and doff, I take [PPE] off and put it in a yellow bin in the bathroom. I have to walk through communal areas with soiled PPE…."

● The provider had stopped analysing accidents and incidents. An entry into the record stated, "Due to Covid-19 it hasn't been possible to maintain a quarterly audit." This meant the provider could not be assured they were protecting people from the risks associated with avoidable accidents and incidents. For example, one person choked, and the paramedics were called. This information was not available at the time of the inspection and instead was identified during our conversations with staff after the inspection.

● At our last inspection, we identified people were at risk of scalds and burns from hot surfaces. At this inspection, we found the provider had fitted radiator covers to most radiators in the home. However, two radiators in communal bathrooms remained uncovered and were hot to touch. Although there was a generic risk assessment in place, the provider failed to undertake individualised risk assessments in line with guidance published by the Health and Safety Executive.

● The provider contacted us after the inspection and told us that, in response to our findings, they had implemented an action plan to improve assessment and care-planning in the service. We have not been able to test the effectiveness of the provider's action plan and we will review this at the next inspection.

Preventing and controlling infection

● People were not protected from the potential spread of infection.

● The provider did not ensure adequate facilities were available for staff and people to wash their hands in

line with published guidance. The provider supplied fabric hand towels for shared use by people and staff in communal bathrooms. This meant people were at risk from cross-contamination. The hand soap dispenser in the laundry was blocked with hardened soap and soap residue. This meant staff could not wash their hands after handling laundry.

● Areas in the home had not been adequately maintained. For example, the surface of one person's toilet seat had perished. This meant bacteria could lodge in this area. The registered manager said, "It's a struggle, it's a small home, the profit margin is very low. We do what we can to make sure people's needs are met. If a decoration can wait, we rather it wait, to meet the people's needs. Things are not getting better, everything costs."

● Items in the home were visibly unclean, this included a chair in the lounge with extensive staining. One relative said, "The lounge is really dingy and it needs doing up." There was a urine stained mattress stored in the bath of a communal bathroom. We spoke with the registered manager who confirmed the mattress was being stored temporarily, until it could be disposed of.

● The provider had failed to review their cleaning arrangements or schedule in response to the Covid-19 pandemic. Dedicated cleaning staff did not work weekends or past 1pm Monday to Friday, frequently touched points were not being cleaned during these times. This placed people at risk from cross-infection. One staff member said, "I don't think the cleaner is given enough hours to clean the home properly, no cleaning is done on the weekend, night staff are supposed to do the lounge, kitchen, dining room and hallway – but to be honest there aren't enough cleaning products."

● Records showed one person's bedroom was not cleaned for four weeks. A chair in the same room was stained and the bin did not have a bag in or lid on.

● There were no foot operated bins being used in the home to dispose of incontinence aids safely. The provider had ordered foot operated bins however these were sealed in their original packaging and not in use at the time of our inspection. In one bedroom there was a bin containing used continence products which had no lid. This resulted in strong and unpleasant odours in some areas of the home and posed a risk from cross infection.

People were at risk of avoidable harm because there was a failure to ensure risks were adequately assessed and managed. There was no analysis of accidents and incidents in the service. Medicines were not managed safely and we found evidence one person had been harmed. There was a lack of effective infection prevention and control measures in place. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider was using body maps to direct staff where to apply topical creams and staff recorded this in peoples' records.

● The provider did replace most of the communal fabric towels with paper towels as a result of our feedback. However, a fabric towel remained in the communal ground-floor bathroom.

● Hand sanitiser was available throughout the home and staff were wearing personal protective equipment (PPE) including gloves, masks and aprons. One relative said, "Whenever I've seen the staff, they have the masks and gloves on and had temperature."

● We observed a member of domestic staff cleaning until 1pm on both days of the inspection.

● We made one referral to Controlled Drug Reporting about the controlled drug error.

At our last inspection we identified the provider had failed to ensure there was a systematic approach to deploying staff across the service. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The provider could not be assured there were sufficient numbers of suitably qualified staff deployed across the service.

● The provider was not using a systematic approach to assess staffing levels in the home. Instead, specific numbers of staff were allocated across the service according to shift patterns. The provider could not be assured there were sufficient numbers of staff to meet people's needs.

● We received mixed comments from staff about staffing levels in the home. One staff member said, "No – it's hard work, when I'm on duty I try not to keep them [people] waiting", and another staff member said, "Usually there are enough staff."

● We received mixed comments from relatives about staffing. Comments from relatives included, "There are always staff there" and, "Usually enough staff, like most places a bit short because of illnesses and things."

● The provider could not be assured staff training was up to date. This was because the provider's staff training record did not include information about when staff training had been completed and when it was next due. A note on the record stated, "Please note, in view of the Covid-19 restrictions and period of lockdown, most of the training for 2020-2021 have been done online and in-house small group coaching." This meant staff may not have up-to-date relevant training to meet the needs of people.

● Staff did not always have relevant training to meet the needs of people living in the home. For example, the provider had failed to ensure they were able to safely care for people with assessed mental health needs. They had not carried out assessments to determine the skills and experience of staff at the service. This meant they had not adequately assessed the needs of three people with mental health needs."

The provider did not have sufficient oversight of staff training. Staff did not always receive training relevant to people they were supporting in the home. The provider was not using a systematic approach to determine how staff were deployed across the service. 18 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager acknowledged staffing levels had fallen below what they would usually expect, they said, "We have been short [staffed] – I have been doing kitchen duties and stuff." Staffing levels had been impacted by the Covid-19 pandemic and we considered this when making our judgement.

● Staff we spoke with confirmed the provider undertook checks with the Disclosure and Barring Service (DBS) and with their former employer.

● At our last inspection we identified the provider had failed to ensure people were always protected from the risk of potential abuse. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from the potential risk of harm and abuse.

● The provider did not always investigate when people sustained unexplained bruising. For example, one person's body map showed they had sustained unexplained bruising. No information was recorded about how the bruising had happened and the provider failed to investigate the cause.

● The provider failed to identify when a person's bruising may indicate potential abuse and this meant they did not contact the local safeguarding team. One person was re-admitted to the home with bruising to both of their wrists and their groin. The provider failed to contact the local safeguarding team about the bruising. We contacted the local safeguarding team. However, the provider's failure to refer the incident when it happened meant no further action was taken because too much time had lapsed.

● The provider did not have oversight of safeguarding in the service. Safeguarding information was recorded alongside information about different types of referrals and was incomplete. This meant the provider would not identify potential safeguarding themes and trends.

There was failure to ensure people were protected from potential abuse and harm. Occasions of bruising were not sufficiently investigated or referred to external organisations. There was no oversight of safeguarding in the service. This was a continued breach of regulation 13 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We made four safeguarding alerts to the local authority safeguarding team in relation to concerns we identified during our inspection.
● Staff spoke confidently about how they would identify potential abuse and what they would do if abuse was witnessed or suspected. Comments from staff included, "I would report [suspected abuse] to the registered manager. I would have no hesitation. I look for bruising, poor appetite, reluctance to talk, marks on the skin" and, "No concerns. When I have had concerns I have gone to [registered manager's name]. If I suspected I would go to [registered manager's name]. If I wasn't happy with this I would call [the Local Authority]".
● The registered manager said they operated an open door policy and encouraged staff to approach them with concerns. There was a whistle-blowing policy in place.

Learning lessons when things go wrong
● The provider could not be assured they learned lessons and improved the service when things went wrong.
● There was no formal system used to identify when things went wrong so the provider could implement change, drive improvement and prevent a recurrence.
● The registered managed told us they had informal discussions with staff when lessons could be learned.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question had deteriorated 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.

● At our last inspection we identified that the provider had failed to ensure their governance system was used effectively to identify shortfalls, errors and omissions. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The governance framework, checks and audits were not used effectively to identify concerns, errors and omissions we identified during our inspection.
● Audits had not always been used effectively to identify shortfalls. For example, the medicines audit failed to identify that protocols for 'as required medicines' contained insufficient information and guidance for staff. Additionally, the audit had not identified when one person received the incorrect dose of a controlled drug over seven days. At the time of our inspection, there was no record of what actions had been taken to prevent a recurrence, and the provider could not be assured people's medicines were being administered safely.
● Provider checks failed to identify that the temperature of the medicines fridge exceeded safe ranges. For example, records detailed the fridge temperature had substantially exceeded 8°C for 14 consecutive days. The error was not identified and no action was taken to ensure the fridge remained within safe temperature ranges. This meant one person was at risk of receiving ineffective Insulin.
● Environmental checks had not identified potential risks we found during our inspection. For example, two radiators were uncovered and hot to touch and the medicines fridge used to store insulin was unlocked and accessible to people. This meant people were at avoidable risk of harm.
● Information about potential risks to people was not always easily accessible to staff. Hand written entries were not always legible and the care-plans were not amended to reflect changes to people's care needs. Instead, entries were summarised in 'Review/Evaluation' records. The registered manager said, "In terms of paper work, we do everything by hand. We can't afford electronic [care-planning]. We write everything down, in terms of reviews, this is something I wish I could improve but I can't do it now, I haven't got the facilities."
● During our inspection, we observed peoples' medicines records left on the medicines trolley in the communal dining area. This meant peoples' confidential information, such as information about medicines they were receiving and personal health information, could be accessed by unauthorised people, staff and visitors
● Provider checks failed to identify shortfalls in relation to infection prevention and control. For example,

the provider did not identify the lack of adequate hand washing facilities for staff and people and failed to review cleaning arrangements in response to the Covid-19 pandemic.

Continuous learning and improving care
● The provider could not demonstrate they were continuously learning and improving care provision in the home.
● There was no formal analysis or assessment to show how the provider had improved care provision and learned lessons when things went wrong in the home.

The provider failed to ensure there was a robust governance system in place. The checks, audits and systems in place were not used effectively to identify shortfalls, errors and omissions. Peoples records were not stored securely. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager said they displayed relevant leaflets and information around the home, they also checked the Care Quality Commission website for updates and could ask the Local Authority to find out about new guidelines.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider did not ensure there was always an open and honest culture in the home.
● The provider was not always open and honest with people. When people had a confirmed case of Covid-19, they did not always tell them. Instead, people were told they had a cold. No mental capacity assessments or best interest decisions were undertaken to help determine if this was the correct course of action. This meant people could have capacity to understand they had Covid-19 and were entitled to know but were not informed.
● The registered manager said they operated an open door policy and encouraged staff to speak with them about concerns.
● Staff we spoke with said the registered manager was approachable. One staff member said, "I haven't had problems approaching [registered manager] - I haven't approached [them] about concerns in the home, personal things they are brilliant with" and another staff member said the registered manager was, "Very approachable and accommodating."
● Staff said their colleagues were caring and they worked well together as a team. Comments from staff included, "We have a good team at the moment" and, "The care team are very caring." One relative wrote, "Thank-you to all the wonderful staff for all of the care and kindness you showed to Mum that made her last years so comfortable. From the bottom of our hearts another thank-you. Definitely Home from Home
● Staff spoke about people in a person-centred way.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider was not consistently engaging with people, relatives and staff.
● The most recent staff, relative and people surveys had been completed in 2018.

Working in partnership with others
● The service was working in partnership with others. During our inspection, we observed a phlebotomist and district nurse visiting with people. One professional said, "The care home are always very helpful and caring for their residents, I have no concerns."
● When people's health had deteriorated, the provider referred them to the relevant healthcare

professionals.

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

- The registered manager was not clear about their responsibilities in relation to the duty of candour, they did not understand what the duty of candour referred to.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was failure to ensure people were protected from potential abuse and harm. Occasions of bruising were not sufficiently investigated or referred to external organisations. There was no oversight of safeguarding in the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure there was a robust governance system in place. The checks, audits and systems in place were not used effectively to identify shortfalls, errors and omissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not have sufficient oversight of staff training. Staff did not always receive training relevant to people they were supporting in the home. The provider was not using a systematic approach to determine how staff were deployed across the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of avoidable harm because there was a failure to ensure risks were adequately assessed and managed. There was no analysis of accidents and incidents in the service. Medicines were not managed safely and we found evidence one person had been harmed. There was a lack of effective infection prevention and control measures in place.

The enforcement action we took:

Warning Notice