Care Quality Commission

# Westholme Clinic Limited

# Westholme Clinic Limited

**Inspection report**

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## Ratings

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

## Overall summary

The inspection took place on 3 and 10 February 2015 and was unannounced. At the last inspection in October 2014 the provider was in breach of Regulation 10, Assessing and monitoring the quality of service provision. This was a continued breach from a previous inspection in May 2014. The provider failed to meet their action plan following both inspections and had not made the necessary improvements at this inspection.

The service provides care and nursing care for older people living with dementia and other mental health conditions. It is registered for up to 55 people and 35 people lived there at the time of our inspection. There was a registered manager in place. The registered manager was also the nominated individual. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers and nominated individuals, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

# Summary of findings

People's safety was being compromised in a number of areas. The management of medicines was unsafe and we asked the provider and registered manager to take urgent action to rectify this. They notified us within the timescale that they had taken the necessary immediate action. The management of risks relating to people who were nursed in bed, at risk of pressure area damage and those with diabetes, was inadequate. This put people at risk of serious harm. Mental capacity assessments were not carried out; this meant people were at risk of receiving care and treatment that they had not consented to. Staff demonstrated kindness and compassion. However, their interventions with people were task focused and activities did not reflect people's individual needs and preferences. Care plans lacked information about people's specific needs and they were not kept up to date.

There was a complaints policy in place and a system to record and investigate complaints which we saw was being used. The provider carried out some audits, however these were not used to inform and implement improvement. The provider had given CQC an action plan stating what they would do to meet the requirements of the law. However, this was not being followed or monitored to reach compliance with the essential standards of safety and quality.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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?**

**Inadequate**

The service was not safe. Appropriate arrangements were not in place for storing, administering, recording and disposing of medicines.

Risk assessments were not in place to ensure people were protected from the risks of harm.

Not all staff had a good understanding of safeguarding. However, when alerts were raised, the home worked with the local authority to resolve them

Staffing recruitment procedures were being followed but information about qualifications was not always recorded. People felt there were enough staff, however there was not a system in place to review staffing levels.

**Is the service effective?**

**Requires Improvement**

The service was not always effective. The requirements of the Mental Capacity Act 2005 were not followed. Mental capacity assessments were not completed and decisions made on behalf of people were not made in accordance with the legislation.

Staff did not have an understanding of Deprivation of Liberty Safeguards and did not know when it should be applied.

People were not offered choices of food or drink. When people lost weight appropriate action was not taken.

The environment of the home had not been adapted to meet the needs of people who lived there.

**Is the service caring?**

**Requires Improvement**

The service was not always caring. Staff were caring in their attitude to people and knew them well. They were however task focused and there was not always evidence of how people's views were incorporated into the planning and delivery of social activities.

People's privacy and dignity was not always respected.

**Is the service responsive?**

**Inadequate**

The service was not responsive. People were not involved in the writing of their care plans and they did not contain sufficient information to allow staff to deliver care in a personalised way.

There was a lack of activities to meet people's individual needs. Activities were not based on individual needs and preferences and lacked meaning to people.

People's health needs were not reviewed and documented in a way that protected them from inappropriate care and treatment.

# Summary of findings

People knew how to complain and felt comfortable talking to the manager and staff about concerns.

**Is the service well-led?**

**Inadequate**

The service was not well led. Action had not been taken to address previous breaches of Regulations we had identified. Audits were in place. However, these were not used to make improvements to the service people received. The system used to assess and monitor quality was not effective.

People were not actively involved in the service. People's views were not sought by the provider.

Information from accidents and incidents was not used to drive improvement to the quality of care people received.

# Westholme Clinic Limited

**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.

This inspection took place on 3 and 10 February 2015 and was unannounced.

The inspection team consisted of an inspector and an expert by experience on 3 February and an inspector and a specialist advisor with experience in the needs of individuals using this type of service on 10 February. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was dementia care.

Before the inspection we reviewed information we held about the service including notifications. A notification is information about important events which the service is required to send us by law. We had received a number of complaints from relatives and members of the public about the management of medicines, the safety, suitability and cleanliness of the building and the care and welfare of people who lived in the home. Some of these were referred to the local authority safeguarding team.

It was not always possible to establish people's views due to the nature of their conditions. We spoke with six people and five relatives. To help us understand the experience of people who could not talk with us we spent time observing interactions between staff and people who lived in the home.

We also spoke with the owner, the registered manager, seven care staff, one housekeeping staff, and two social care professionals. We looked at care plans and associated records for 14 people, staff training records, four staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

Inadequate

# Is the service safe?

## Our findings

We had received complaints from relatives and members of the public about the safety of people who lived at Westholme Clinic. We were told medicines were left unattended and people were at times left without care and support. People and their relatives that we spoke to during the inspection said they felt the home was safe. One relative said this was, "Because the way the staff manage [my relative], always a calm and structured approach. They cope with her physical and mental needs." Another relative said their spouse was, "Well looked after, [they] cannot do anything for [themselves]….. You put your faith in people".

Medicines were not stored or disposed of safely. In the hall, a communal thoroughfare close to an exit door, we saw there were four green bags, the kind used to transfer medicines to and from the pharmacy. The bags were closed but not securely shut. We opened and looked in the bags and found they contained medicines that had been prescribed for people who lived at the home. People had open access to the area where we saw the bags which contained, amongst other things, 55 tablets or capsules in the psychotropic group of medicines which meant they would be hazardous if taken by people in error. Staff were not able to tell us why these medicines had not been administered and were being returned unused to the pharmacy. The registered person had failed to protect people against the risks associated with the unsafe storage of medicines.

The medicines and clinical room was untidy with six full sharps bins on the floor, one was not sealed. Sharps bins are used for the safe disposal of sharp objects such as syringes. We spoke to the nurse about this who told us "We keep phoning them [the bin providers] but they won't come to get the bins, we have not had a sharps box for a while, although in an emergency we can use the district nurses." We found a large cardboard box under a counter in the clinical room that was overflowing with various medicines and medicines fell on to the floor when we moved it. We found three tablets that looked like they had been on the floor for some time. They could not be identified by the nurse in charge. There was no record of any of the medicines in the box.

We had received complaints prior to our inspection that medicines were left unattended. On the first day of our inspection we observed a nurse giving out the lunch time medicines. They unlocked the medicines trolley in a communal area, near the front door and dispensed medicines into a pot. They then went to the far side of the lounge to support the person in taking their medicines. The trolley was left open and unlocked facing four people sitting on sofas opposite approximately two feet away. This happened three times over the course of approximately 25 minutes. When we asked the registered manager about this they said normally two people do medicines but because of the inspection the nurse had done it on their own rather that disturb the registered manager who was talking to the inspector.

Medicine administration records (MAR) were not accurately kept. We looked at the medicine administration records for eight people and found that typed pharmacy instructions were crossed off by hand and replaced with new hand written instructions which had not been signed or dated. We were told by a nurse the nursing staff made these changes because the pharmacy got things wrong. Records showed that medicines had been given at different times and/or incorrect doses were given. For example, one person was prescribed a medicine for severe pain three times a day. According to the MAR this had not been given. This left the person at risk of suffering pain. Their care plan did not indicate why it had not been given. Another person had been prescribed a medicine for depression. It had been prescribed for night-time, however, this had been crossed off the medicine administration records and 18.00 inserted in hand writing. Their care plan did not indicate why it had been changed. This medicine had a side effect of drowsiness and if given at 18.00 the person may have fallen asleep early in the evening. We spoke to the nurse and the registered manager about the medicine administration records and the concerns about recording. The nurse told us, "We give the medicine when the person needs it so sometimes it may be different to the MAR." The registered manager told us, "The pharmacist keeps getting this wrong even though we tell them." People were at risk of not receiving their medicines as intended by the prescribing doctor.

The failure to ensure that medicines were administered, recorded and stored correctly is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The premises were not safe. In an unlocked corridor close to the entrance hall we found a storage room which was

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# Is the service safe?

not locked. This contained bottles of bleach, bottles of carpet cleaner and bottles of floor wash. The bleach in particular carried a hazard warning notice and this meant the products should have been maintained in a secure manner.

In a communal corridor we found an open box containing 10 bottles of baby bath and six bottles of baby shampoo. The bottles were brightly coloured yellow and blue and were easy to open. We saw three people walked up and down past these boxes four times in a ten minute period. During this time no staff were available to supervise the people who walked by. We considered this could have placed them at risk because their mental health conditions may have meant they would not have a good understanding of the identification of and safe use of the products.

Staff had noted maintenance issues however these were not always actioned. For example, we saw a record from December 2014 stating that there were exposed pipes in one person's bathroom. We checked this room and found there were still exposed pipes with screws sticking out and torn flooring. There was no risk assessment to show how the person was protected against the risks this posed.

The failure to ensure that people are protected by safe premises is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that a record of incidents and accidents was kept. We asked if any analysis of these had been undertaken to establish causes, patterns and any learning from them. The registered manager told us no such analysis had been done. This meant people were not protected from avoidable harm because there was a failure to identify, assess and manage risks relating to the health, welfare and safety of service users.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider was working co-operatively with the local authority safeguarding team. The provider had a policy on safeguarding which included appropriate information. Staff had received training on safeguarding, however not all staff fully understood what this meant. For example, one person said, "It is for their safety. I would report something like a broken chair arm or a badly positioned fire extinguisher that was at risk of falling."

Staff and relatives told us there were always enough staff on duty, including domestic, nursing and maintenance staff. The numbers on shift during our inspection reflected the rotas. We saw that although interactions were positive staff were very busy and remained task focused when meeting people's needs. People were often left unattended in the communal areas and there was not enough documentation to evidence that people in their rooms were attended to in accordance with their needs. Pre admission assessments included details of people's hobbies, interests and social needs, however this was not translated into care plans or care delivery.

**We recommend the provider reviews staffing levels according to the needs, including social needs, of individuals.**

Records showed staff had appropriate recruitment checks before working in the home. This included criminal record checks, nurses registrations and permits to work where applicable. This protected people from being cared for by unsuitable staff.

Requires Improvement

# Is the service effective?

## Our findings

Staff had limited or no understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act aims to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making. The Deprivation of Liberty Safeguards concern decisions about depriving people of their liberty, so that they get the care and treatment they need, where there is no less restrictive way of achieving this. Staff did not think there was anyone affected by either DoLS or MCA. Staff did ask people for their consent prior to carrying out any procedures but this tended to be brief and task related. For example, one staff member said, "I am going to give you your lunch now, okay?" This was a common approach of staff with people. This meant people were at risk of receiving care that they had not consented to and/or was not in their best interests.

The registered manager told us that they had not undertaken mental capacity assessments on any of the people who lived at the home. They said this was done by other professionals prior to admission. The registered manager did not have copies of these assessments and they were unaware that staff at the home should have completed these. People's care plans referred to their mental capacity to make decisions. For example, in one it stated, "Due to dementia she is unable to input into her care planning or make decisions to keep herself safe". There was no reference to the person's ability to make choices in other aspects of daily living such as what they ate and activities they could participate in. In the three records we reviewed we found there were 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms that had been signed by relatives. However the records did not contain evidence that the relative had the legal right to sign these forms or that the decision had been made in the person's best interest. Another care record we looked at stated, "Unable to make decisions" but there was no assessment or record of how this was established.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People did not receive effective care. For example we saw one person had a sheet that did not fit their bed, a bed rail that was broken and a bumper (to protect them from injury of the bed rail) that was dirty and ill fitting. There were no risk assessments for the bed rail and bumper. There was no pressure care risk assessment or care plan for this service user who was nursed in bed at all times. There were no records of how often this person was turned in bed. This person had two wounds on their foot that had not been identified, recorded or treated.

People had contact with GP's, podiatrists, care managers and district nurses. However their health needs were not fully met. People with pressure wounds did not have pressure wound care plans. The lack of detail, photographs, measurements and body maps meant staff could not monitor improvement or deterioration. People with diabetes did not have diabetic care plans. Blood sugar levels were taken but there was no guidance for staff to know what a high or low level was for individuals. This meant people were at risk of being seriously ill because would not know when to intervene or seek medical help.

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

People told us they were satisfied with the food and drink provided. Staff offered and provided drinks between meals and they helped those that required assistance with their drink. During meal times people were supported in a calm, relaxed manner with interaction from staff. A relative told us they liked that staff thought about where people sat to eat so that they were 'compatible'. We saw that some people who needed support to eat were given this on a one to one basis and staff sat beside them, talking to them and encouraging them. However, we saw one example of a member of staff assisting somebody to eat whilst standing beside them and keeping an eye on another table. This staff member was therefore supporting people at two different tables.

When people had a diagnosis of diabetes their record referred to them having a "diabetic diet". There was no specific guidance about what this meant to the individual in terms of their target nutritional intake. This did not reflect the differences between individuals with diabetes in terms of their unique needs. A visiting social care professional told us they had asked the chef about any special diets or menus for people with diabetes. The chef said there were not any. The registered manager later said there was but these were not seen. We also noted that although people said they liked the food we did not

Requires Improvement

# Is the service effective?

observe people being given choices. The only example of choice we saw was that one person had a glass of wine with their meal. All other food and drink was given to people without any options being offered.

People told us they liked the layout of the home, they commented that they could walk around freely and the wide corridors were suitable for this. We saw people used the conservatory where they had a view of children playing in a school playground. Several people commented on how lovely this was and we saw they got a lot of pleasure from it. One relative said of the premises, "It could do with a coat of paint." There were areas that were worn, paintwork was marked and skirting boards were chipped. There had been little effort to ensure the home was suitable for those living with dementia. For example, some doors had numbers, some had pictures and some had both but a lot were in need of repair, for example room 31 only showed the number 3. This could be very confusing for someone with memory problems. Since the last inspection the provider had introduced colourful bathroom, toilet and other communal room signs. However, the signs were high and out of some people's line of sight.

**We recommend the provider sources some professional guidance on making the home suitable for people living with dementia.**

Staff said they were well trained and had received training in a variety of areas. These included first aid, safeguarding, moving and handling, fire awareness and infection control. Some training had been provided by external trainers and other courses were provided by the registered manager who had undertaken train the trainer courses. Staff were supported to undertake further qualifications such as National Vocational Qualifications which are work based awards that are achieved through assessment and training. Staff told us the training was effective and when we observed, for example, people being moved and handled we saw this was done safely and appropriately.

Requires Improvement

# Is the service caring?

## Our findings

People told us they liked the staff, they said they were "lovely" and "wonderful". Relatives and visitors we met during the inspection told us it was a caring home. They said they felt their loved ones were in good hands.

People's privacy and dignity was not always respected. For example we saw a member of staff enter a room without knocking then apologising to the person and saying they would come back later. On another occasion someone's trousers had fallen down and they needed assistance. We had to find a member of staff and request this.

There was little evidence people were involved in decisions about how the home was run. Care plans gave no indication people or their relatives had been involved in their development. Care and support was not individualised. It was not possible to establish if people's recorded choices were supported. Staff interaction with people was often task focused and there was not always evidence of how people's views were incorporated into the planning and delivery of their care or social activities.

Staff knew people well and were caring in their approach. Many of the staff had worked at the home for years and had built relationships with people. People were visibly pleased to see certain members of staff. One spontaneously said, "Here's [name of nurse] he's a wonderful man. Staff were polite and friendly to people although they were task focused. Staff told us they loved their work and care about the people in the home. One said "I like being around the elderly. I like to care for people."

Inadequate

# Is the service responsive?

## Our findings

People were at risk of not receiving the care they required. People who had a diagnosis of diabetes had inadequate care plans to ensure this need was met. Care plans lacked guidance about how to monitor complications associated with this health condition. Where people had other health conditions that may have been as a direct result of this condition, nursing staff had not identified this and plans had not been developed to meet all of people's needs. For example, people's weights were recorded. We saw that where one person had lost weight for three consecutive months no action had been taken. There was no guidance to inform staff at which point they should intervene. This meant people were at risk of not having their needs met because of a lack of staff action.

The service was not always responsive to individual needs. Assessments and care plans were not tailored to individuals and did not include details on how each person's specific needs should be met. People had not been involved with the planning of their care. This meant people were at risk of receiving care and treatment that was not personalised to their individual needs.

One person's admission summary stated "[Name] will be supported with a programme of mental stimulation and physical activity suitable to [their] needs and abilities. Give [them] daily one to one time. Find out things [they] likes doing and support him with them". It also stated they were "sociable". This was dated 19 August 2014. Their care plan did not reflect their interests or preferences and there was no evidence of one to one activities or individual mental and physical stimulation. The registered manager told us there were no individual activities planned for people. We were told that group activities took place every afternoon. We observed one activity over the two days we were there. The activity log recorded the activities and the names of the participants. We looked at the log for 2015. Some entries were not dated and there was not an entry for every day of January 2015. Most entries said "music, games and exercises". There was no evidence that activities reflected people's needs, preferences or known interests.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's individualised health care needs were not always met. For example, people with diabetes did not have detailed care plans to reflect their specific needs. We saw people's glucose levels were tested and recorded but there was no information about what staff should do if they were higher or lower than levels which were agreed as acceptable for the person. People with pressure area damage did not have suitable pressure area care plans. There were no body maps, measurements or photographs to monitor whether pressure damage was improving or worsening. We saw a record in one person's care plan dated 21 January 2015 that stated, "Social Worker would like to see charts re [person's name] sore areas. Please measure wounds and record". When we asked the registered manager whether this had been done for this person or other people with pressure wounds they said, "You asked me that the other day, we don't have anything like that."

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

People and their relatives told us they could talk to the registered manager, nurses or any of the care staff if they had any concerns. We saw relatives going into the registered manager's office to discuss things. There was an open and friendly relationship between staff and visitors. The provider had a complaints policy. Details of the complaint procedures were displayed in the home, and gave details of who people could complain to. We saw that complaints were recorded in the complaints log with the details of any actions taken. This meant people could be reassured their concerns would be listened to and acted upon if they were able to verbally complain or raise concerns. However there was no process of engaging with people who used other forms of communication or had cognitive impairments which meant they could not verbally complain.

Inadequate

# Is the service well-led?

## Our findings

At our last inspection we raised concerns about the quality monitoring of the home. In the action plan dated 18 December 2014 the provider told us, 'We are putting a daily checklist in each bedroom that will have to be filled in by the carers after they have checked on maintenance issues, cleanliness and tidiness, creams/lotions are for correct resident, care plans and risk assessments are up to date.' At this inspection we were told these were not in place. This meant people's rooms, risk assessments and care plans were not audited according to the provider's action plan. Issues that may have been identified by quality monitoring systems were missed. For example we saw one person had a sheet that did not fit their bed, a bed rail that was broken and a bumper that was dirty and ill fitting. There were no risk assessments for the bed rail and bumper. There was no pressure care risk assessment or care plan for this service user who was nursed in bed at all times. There were no records of how often this person was turned in bed. This person had two wounds on their foot that had not been identified, recorded or treated.

The registered manager had not ensured the service being delivered was person centred. There was no evidence of people's involvement in their care planning and no mechanism for establishing people's mental capacity. Although the atmosphere in the home was relaxed and calm people were not receiving person centred, high quality care.

We asked what systems were in place to audit care plans and risk assessments. The registered manager told us, "I know the care plans aren't good, they need doing." We asked if there was a plan in place to audit care plans and risk assessments and were told there was not. Due to a lack of auditing, care plans were not kept up to date, were not reflective of people's needs and therefore people were placed at risk. For example, people with pressure sores and diabetes did not have suitable care plans to protect them from the risks associated with these conditions.

This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People spoke highly of the registered manager and a genuine rapport was noted between them and relatives and people who lived at the home. The registered manager told us that they liked to be "hands on". We saw that they got involved in delivering care and serving meals. They also delivered training. This meant many of the management tasks were at risk of not being addressed such as ensuring care plans were reviewed and updated.

The home had a calm and relaxed atmosphere. Relatives and professionals told us that this was something they liked. People talked about the calm approach of the registered manager and how this was cascaded to staff. Staff said they were well supported by the registered manager and felt at ease to raise concerns or ask questions.

The leadership style of the home meant that standards of care and treatment were inadequate. For example, the registered manager told us they had delegated medicines management to another member of staff. However, they had failed to monitor this and this resulted in medicines management being unsafe.

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 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment<br><br>The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. |

| 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<br><br>The registered person did not ensure that service users and others having access to premises<br><br>where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises.<br><br>This was a breach of Regulation 15 (1) (c) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services<br><br>The registered person did not have suitable arrangements in place to ensure service users are enabled to participate in decisions relating to their care and treatment. |

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br><br>People did not have assessment to identify when they were in pain and how staff would be able to establish if people's pain was increasing. Regulation 9 (1) (a) (b)(i) (ii)<br><br>People did not have care plans to address areas of identified need. Staff did therefore not have guidance on how to meet the needs of people. Regulation 9 (1) (a) (b)(i) (ii) |

**The enforcement action we took:**
Warning Notice served on 9 March 2015. To be met by 4 April 2015

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br><br>The registered person had not protected people against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. |

**The enforcement action we took:**
Warning Notice served on 9 March 2015. To be met by 4 April 2015

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision<br><br>The provider did not have adequate quality assurances in place to assess and monitor the quality of the service provided.<br><br>The provider did not have systems in place to ensure there could be learning from incidents in the home |

This section is primarily information for the provider

# Enforcement actions

This was a breach of Regulation 10 (1) (a) (b) (2) (c) (i)

**The enforcement action we took:**
Warning Notice served on 9 March 2015. To be met by 4 April 2015