Care Quality Commission

Harbour Care (UK) Limited

Anchor House

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

This was an unannounced comprehensive inspection carried out on 19 and 20 October 2015. Anchor House provides care and support for up to seven people with physical and learning disabilities. This inspection was in response to concerns received about the home. There were seven people living in the home during our inspection.

At the time of this inspection the home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous manager left the employment of the home however had not deregistered with the CQC. Therefore they remain showing on this report. The home had a manager who was also the registered manager for a nearby home.

Although people's needs were being assessed, care was not always delivered to meet people's needs. The

Summary of findings

information in people's care records was not always up to date and some people's plans did not reflect their current needs. This meant people were at risk of receiving unsafe care.

Some mental capacity assessments had been undertaken resulting in best interest decisions being recorded. However some people had 'best interest' decisions in place without a mental capacity assessment. It was not evident in their care plan that the Mental Capacity Act 2005 had been appropriately followed.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines safely. People's medicine administration records were not always correctly completed. Pain assessments were not in place and medicine audits were not taking place. This placed people at risk.

People's physical health was monitored and appropriate referrals to health professionals were made. The provider worked effectively with health professionals and made sure people received good support when they moved between different services.

Activities were provided both in and outside of the home.

Records showed that staff had received safeguarding training and understood their responsibilities in relation to protecting people from abuse.

Whilst there were enough staff on duty to meet people's needs, feedback received from some staff was that the home was understaffed, which meant staff worked longer hours and shifts. Staffing levels had not been calculated based on people's needs.

Staff were not receiving appropriate supervision in accordance with the provider's supervision policy.

Robust systems were not in place to assess and monitor the quality of the service provided.

The provider had not ensured that the home was kept clean.

The provider was not ensuring that people were protected against the risks of inappropriate or unsafe care and treatment as effective analysis of accidents and incidents and audits had not been carried out.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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.

Systems for the management of medicines were unsafe.

People and others were not protected against the risks of unsafe premises.

Infection control procedures were not robust.

Is the service effective?

Requires improvement 

Improvements were required to ensure the service was effective.

Staff were not receiving regular supervision.

People's rights were not protected because the provider did not always follow the principles of the Mental Capacity Act 2005.

Staff were aware of people's dietary needs and preferences. Improvements were required to ensure people had a choice of food.

Is the service caring?

Requires improvement 

Improvements were required to ensure the service was caring.

We observed staff supporting people in a caring manner, however this was compromised by the culture of the home

People told us they liked the staff who had got to know them and understood their needs.

Is the service responsive?

Inadequate 

Care plans did not always include sufficient information about people's care and support needs. This meant staff did not have up to date information to tell them about people's individual needs and how to provide personalised care.

People's need to be kept occupied and stimulated was met.

People were not supported to raise a complaint as it was not readily available to people in an easy read format.

Is the service well-led?

Inadequate 

Systems for checking and monitoring the service were poor. This meant shortcomings in the home and the service people received were not always identified and responded to promptly.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

There were a poor culture in the home with allegations of bullying, poor communication, and staff not working together.

Anchor House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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 19 and 20 October 2015 and was unannounced. There were two inspectors in the inspection team. We spoke with one person living in the home and met with five others. Because some people were unable to tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the manager, regional manager and three members of care staff.

We looked at four people's care and support records, two people's medicine administration records and documents about how the service was managed. These included staff training files, one staff recruitment file, audits, meeting minutes, training records, maintenance records and quality assurance records.

Before our inspection, we reviewed the information we held about the service. This included the information about incidents the provider had notified us of. We also contacted one local commissioner and the local authority safeguarding team.

We did not ask the provider to complete a Provider Information Return before our inspection. This is a form that asks the provider to give us some key information about the service, what the service does well and the improvements they planned to make. This was because we prioritised this inspection as a result of concerns that had been raised.

Inadequate

Is the service safe?

Our findings

Most of the people living at Anchor House had limited verbal communication; therefore we spent time observing how people spent their time. People were relaxed and at ease in each other's company. Most people had lived together at the service for many years. One person who was able to talk to us told us they felt safe living at the home. They told us, "The staff are cool, I feel safe". People interacted well with the staff who clearly recognised the level of support they needed.

People did not always receive their medicines safely. Medicines were stored in a locked cupboard in a storage room. There clear guidelines in place to support staff with the administration of medicines. Staff were trained in the safe administration of medicines. We looked at a selection of people's MAR (medicine administration records) and saw that there were gaps in some of these. For example, one person's MAR indicated that they had not received their prescription for clonazepam which is used to treat seizures. Another person's MAR indicated that on one day that had not received their prescribed lamotrigine which is used to treat epilepsy. This meant that there was a risk that some people may not have received their medicines as prescribed.

We found that staff had not been competency assessed in relation to the management and handling of medicines. We looked in the homes incident book and saw three recent instances where medicine had been found on the floor of people's bedrooms by members of staff. This meant that people had not received their medicines as prescribed, to meet their health needs.

Some people living in the home were prescribed PRN (as required) pain relief. However they could not verbally express pain. We found that pain assessments were not being used for these people by staff in the home. This meant that there was a risk that a person may not receive pain relief as staff may not have recognised the signs that the person was experiencing pain.

We looked at the homes systems for medicine storage. We saw that these were stored appropriately. However we identified discrepancies with the number of one drug in the cupboard to the amount recorded in the specialist medicines record book. Staff were unable to account for what happened to this medicine.

We saw records that showed one person who lived in the home received covert medicine. We saw the best interest decision to support the use of this medicine had not included the person's GP or pharmacist. NICE (National Institute for Health and Care Excellence) guidelines that when covert administration of medicines is being considered, there should be a 'best interests' meeting. A best interests meeting should be attended by care home staff, relevant health professionals (including the prescriber and pharmacist).

We asked to view the homes medicine's audit. However both the manager and staff were unable to locate a recent audit. The last audit that was located was completed in January 2015. This meant that the provider was unable to identify and protect people against the risks associated with the safe storage, handling and administration of medicines.

This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to the safe management of medicines.

People were not safe as their health needs were not always identified and then acted upon. We saw care plans contained risk assessments which were specific to the needs of the individual. For example we saw assessments had been completed regarding pressure area care and finance. However we found that care plans and risk assessments had not been regularly reviewed which meant that people were at risk of unsafe or inappropriate care. Many of the risk assessments we looked at had notes on stating 'requires updating'. Which meant that the risk assessments may have not reflected the level of risk and plan of care for people living in the home. This meant people were at risk of receiving unsafe or inappropriate care or treatment.

We checked one person's emergency first aid bag and found that it had a syringe in it which was not dispensed with the single use medicine for which it was prescribed. We also saw dressings in the bag which had passed their use by date. The bag contained confidential information for two other people who lived in the home.

This was a breach of Regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to assessing the risks to the health and safety of people using the service.

Inadequate

Is the service safe?

The service did not have robust systems to ensure the home was clean. During the first day of our inspection we took a tour of the premises. We found that the floors in people's bedrooms were visibly dirty and one bedroom had tree leaves on the floor. One person's pillow and sheets were visibly dirty and had a strong smell of odour. There was an empty bottle of hand gel in the entrance of the home, which remained empty for both days of our inspection.

There were records in place that that prompted staff to clean different areas of the home, however these were mostly incomplete. We discussed this with the manager who told us that it was staff responsibility to ensure that cleaning took place within the home.

This was a breach of Regulation 15 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to ensuring that the premises and equipment were kept clean.

We found that equipment had not been serviced in line with manufacturer's recommendations. For example the homes hoists and beds had not been checked and serviced. The manager explained that this had been picked up in a recent audit and equipment in the home was due to be serviced on the day of our inspection. During the second day of our inspection we saw that the equipment in the home had been serviced. Portable Appliance Testing had been completed. Emergency lighting, fire alarms, fire doors and gas safety were all periodically tested.

Legionella testing had been taken place on 28 October 2013. Legionella are water-borne bacteria that can cause serious illness. Health and safety regulations require persons responsible for premises to identify, assess, manage and prevent and control risks, and to keep the correct records. We saw that staff were completing tasks such as cleaning and descaling the showerheads quarterly and running infrequently used taps in order to minimise risks.

People living in the home had personal evacuation plans so that staff and emergency services knew how to safely support them in an emergency. The manager told us that the evacuation plans required updating and they were due to have a meeting with the fire officer in order to obtain support and guidance. They also told us that fire training had been booked for staff to attend on the 12 November 2015.

We discussed staffing levels in the home with the manager. They explained that the home was staffed by 4.7 members of staff during the day and at night-time people were supported by one waking member of staff and one member of staff who slept.

One person told us that there were enough staff to help them when they needed assistance. They told us that staff assisted them promptly. However staff told us they worked long hours which had an impact on people living in the home. They told us that there was an overall shortage of staff, and there were occasions due to staff sickness where people were not supported by the correct amount of staff. The explained that they felt the provider was very reluctant to use agency staff to cover staff absences. They told us that poor practices were starting to happen in the home, such as people being assisted to bed by night staff at set times for the benefit of staff and not in accordance with people's care plans.

The service had a safeguarding policy and procedure in place if abuse were to be suspected. The service also had a copy of the 2015 Dorset wide local authority safeguarding policy. The manager knew who to contact in the event of identifying a safeguarding concern and had access to the local multiagency policy and procedure. When we spoke with staff they knew how to identify possible signs of abuse and that they needed to discuss any incidents with a senior member of staff. The manager told us that to ensure that staff were aware of any safeguarding outcomes where appropriate, they would be provided with updates in team meetings and sign documents to show that they understood this. Staff we spoke with informed us that they had received training and demonstrated that they knew how to identify signs of abuse and were clear about how to report this.

We looked at one staff recruitment record and spoke with one member of staff about their recruitment. We found that recruitment practices were safe and that the relevant checks had been completed before staff worked with people. This included up to date criminal record checks, fitness to work questionnaires, proof of identity and references from appropriate sources, such as current or most recent employers. Staff had filled in application forms to demonstrate that they had relevant skills and experience.

Requires improvement

Is the service effective?

Our findings

The one person that we spoke with told us that they felt staff were well trained. We found that the provider trained staff in the knowledge and skills needed to work in the service including training related to the specific needs of people living in this home. Examples of this were training on crisis management, autism, learning disabilities and safeguarding vulnerable adults.

It was mandatory for all new staff to complete an induction, which included shadowing experienced members of staff. Staff had an initial induction before starting to work in the service. However we spoke with some staff who told us that due to a lack of a manager in the home their induction was delayed.

Staff told us that they had received one supervision with the manager since they had taken over the running of the home in July 2015. We checked these records which corroborated this. However the provider's supervision policy stated that all staff should have a bi-monthly supervision. This was an area for improvement.

We were only able to ask one person if staff sought their consent before providing care and support. They told us that staff sought their consent. During our observations we saw staff asking for consent and asking people what they would like.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. We discussed this with the manager who told us that DoLS had been applied for all of the people living in the home and they were awaiting contact from the local authority. We looked at the records for one person and saw that a DoLS application had been granted. However the provider had not notified the CQC of this as required by the regulations.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009, as the provider had not notified CQC of the outcome of a DoLS application.

The provider had not made suitable arrangements to act in accordance with the Mental Capacity Act 2005. Three members of staff told us that they had completed training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff training records confirmed this. Where needed, people had not always had their capacity assessed in relation to specific decisions so plans could be made and care could be provided in people's best interests. For example, one person had mental capacity assessments in place for the use of bedrails and protective padded cover; however this was not supported by a 'best interest decision'.

This was a breach of Regulation 11 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider was not always acting in accordance with the Mental Capacity Act (2005).

People had enough to eat and drink but did it was not clear how people were supported to have a choice. There was a good supply of fresh food in the fridge, and the freezer was well stocked so there were a variety of foods available. One person told us that the food was good. There was a menu plan on the wall in the kitchen; however it was small and difficult for people with a physical impairment to see. We also noted on the second day of the inspection that people were being prepared a meal that was not on the menu and it was not clear how people had been involved in this decision. We discussed this with the manager who told us that they were arranging a blue board to be used to help people make decisions about meal choices.

People were supported to manage and maintain good health. For example they attended to GP appointments, dentist or opticians. Hospital appointments and more complex healthcare needs were also identified and people were supported to attend these appointments. Information relating to health was recorded in peoples care and support plans to ensure everyone was aware of people's current health conditions.

Requires improvement

Is the service caring?

Our findings

During our inspection we observed staff supporting people in a caring manner. However this was compromised by the culture of the home and staff not working as a team. We were told about culture of bullying, staff working in 'silos', documentation going missing, messages from health care professionals not being communicated and staff discussing work related issues in the presence of people in the home. All of this meant that whilst we observed staff supporting people in a caring manner, people's overall experiences and outcomes were put at risk.

One person we spoke with told us they were happy living at the home. They told us that the staff were, "Cool". They explained that staff treated then with dignity and respect when they supported them. They told us, "They are cool. I am going to work today and [staff member] will take me".

Staff interacted in a positive manner with people and were sensitive to people's needs. People responded well to staff and were comfortable with them. People who were unable to verbally express their views appeared very comfortable with the staff who supported them. We saw people smiling and singing with staff when they supported them.

Staff had a good understanding of people's needs, some of their personal preferences and the way they liked to be cared for. For example, one member of staff knew the type of television that the person enjoyed and assisted them to change the channel. We saw that the person responded positively to this. People's life histories and personal preferences were recorded.

Staff knocked on people's doors before entering and doors were closed when people were assisted with personal care. Staff understood how to treat people with dignity and respect, such as ensuring curtains were drawn and the doors were shut when providing personal care.

We saw that one person was supported to eat breakfast in the morning. We saw that the member of staff provided support and assistance to the person in a sensitive manner. We saw that the person had a clothes protector on and the member of staff sat next to them. We saw that the member of staff supported the person to eat their meal a dignified way and allowed them to finish eating what was in their mouth before offering more. We also saw that the member of staff supported the person to smell their coffee which they enjoyed doing.

One person was distressed and staff reassured them and stayed with them until they were settled. When staff supported people to move they did so at their own pace and provided encouragement and support. Staff explained what they were going to do and also what the person needed to do to assist them.

All of the bedrooms at the home were for single occupancy. This meant that people were able to spend time in private if they wished to. Bedrooms had been personalised with people's belongings, to assist people to feel at home. For example, one person's bedroom had football memorabilia.

Care files and other confidential information about people were kept securely. This ensured that people such as visitors and other people who used the service could not gain access to people's private information without staff being present.

Inadequate

Is the service responsive?

Our findings

One person we spoke with told us that staff understood their needs well.

People had an assessment of their needs completed prior to moving into the home, from which a plan of care was developed. However we found that all of the care plans we looked at contained inaccuracies and required updating.

One person's care plan stated that the person must not be positioned on their back. However there was no explanation as to why this was the case. We looked at the person's records and saw that the person had been repositioned onto their back during the week. We discussed this with staff who told us that the care plan was out of date as further guidance had been obtained from a visiting healthcare professional.

Another person's care plan stated that staff should assist them to use a body brace. However when we spoke with staff we were told that this was no longer being used. We saw that this person's care plan also stated that they used an elbow splint that should be used for a maximum of 30 minutes then removed with hour breaks in-between. However we saw no record of if and when the person was using it. This person had a Percutaneous endoscopic gastrostomy (PEG) and we found that the care plan written by staff for the PEG differed from the care plan given by the healthcare professional. This placed the person at risk of receiving care that did not meet their individual needs. We discussed this with the manager who told us that the care plan had been incorrectly copied. We also found that this person's records were not up to date. For example on the 8 October 2015 there was no record to show that the PEG had been flushed with water in accordance with the person's care plan. We also noted that the syringe used with the PEG had not been changed in accordance with this person's care plan as it was recorded as 'out of stock'. We raised this with the manager who confirmed during the second day of our inspection that the syringe had been replaced.

One person's care plan stated that their oxygen saturation levels should be monitored by staff four times a day. However we found no record that this was being actioned to ensure that staff monitored this person's needs.

Four of the care plans we looked at had yellow notes stuck on many sections of the care plan stating 'requires updating'. However there was no indication of what needed updating. This meant that the care plans were not up to date and people were at risk of unsafe or inappropriate care or treatment.

The above shortfalls were a breach of Regulation 9(1)(a)(b)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as care and treatment was not being assessed, delivered and monitored in a safe way.

Some arrangements were in place for people to inform the manager of their concerns. There were copies of the complaints procedure in the main entrance of the home. However this was not readily available to people in an easy read format. The manager showed us copies of these easy read complaints procedure in one person's care plan and told us that they would arrange for copies of these to be made accessible in the home.

People's needs were recognised and shared when they moved between services. The manager told us that when a person was admitted to hospital staff, provided information explaining why they required hospital support, a copy of their medicine administration record (MAR) and records of their care needs.

Inadequate

Is the service well-led?

Our findings

At the time of this inspection the home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous manager left the employment of the home, however, had not deregistered with the CQC. Therefore they remain showing on this report. The home had a manager who was also the registered manager for a nearby home.

We had serious concerns about the management of Anchor House. Concerns were raised with us both prior to and during the inspection about the culture of the home. This included allegations of bullying, poor communication and staff not working together. We were told that concerns had been escalated to the regional manager but action had not been taken.

There were systems in place to ensure high quality care, but these were not being implemented.

Care plans were in place for each person, but were not up to date. This placed people at risk of receiving inappropriate or unsafe care. Some staff had not received information about whistleblowing during their induction. Many of the records we asked to view were unavailable to us during the inspection. For example staff were unable to locate a recent medicine's audit.

The manager's office was not in the main part of the home but in the garden so they could not oversee staff effectively. They told us that they would be relocating their office into the main part of the home.

The manager explained that they had identified a number of areas for improvement. This included staff supervision, infection control and record keeping. They explained since recently commencing in the role as manager they had conducted a staff meeting in May 2015. We saw the minutes of this meeting. Topics discussed included infection control, control of hazardous substances, documentation and communication. The manager acknowledged that team meetings were not taking place monthly as set out in the provider's policy.

The provider was not completing regular audits in order to monitor the quality of service, and when these were completed and issues were identified these were not always actioned. For example, we looked at the provider's quarterly fire audit. We saw that in February 2014 the audit identified that some of the fire doors were not fitted properly and required maintenance. We looked at the provider's fire audit conducted in June 2015 and saw that the same concerns had been raised with the fire doors and had still not been rectified. We discussed this with the regional manager who acknowledged that this should have been actioned.

The provider had copies of returned questionnaires that had been sent to people living in the home and relatives but was undated. We saw that there were eight responses. We looked at the responses which were mostly positive. However there were some responses that were not. For example, some people did not feel their rooms were kept clean. Others felt that staff did not always give them enough time and were rushed. Another person wanted better maintenance of the garden. There had been no analysis of these responses and no action plan to address any lower scoring areas.

People living in the home had "Your voice" meetings where they were able to share their thoughts and ideas about living in the home. However, we found that these had not been taking place. The manager told us that there was a meeting arranged for the week following our inspection.

The provider was unable to locate their accident book for a period of 30 minutes during the inspection. When it was located we looked at the most recent accidents that had taken place in the home. We saw that accidents were not properly recorded so there was no way of knowing what the accident was. There was no record of any actions taken to identify the potential cause and to prevent reoccurrence. People were not protected from further harm as the provider was not conducting an effective accident and incident analysis.

Records of incidents were kept. However these were not always reviewed and actions taken to reduce the occurrence of these. For example, we found one instance where a person's medicine had been found on the floor by a member of staff. There was no investigation into this

Inadequate

Is the service well-led?

incident and the manager was not aware it had taken place. This meant that people had not received their medicines as prescribed and this may have had a negative impact on their health and wellbeing.

These shortfalls were a breach of Regulation 17 (1) (2)(a)(b)(c)(e) (f) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to good governance.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent How the regulation was not being met: There was a lack of awareness of the principles of the Mental Capacity Act 2005 and a lack of mental capacity assessments and best interest decisions for some people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment. How the regulation was not being met: The premises and equipment was not kept clean.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Regulation 18 Care Quality Commission (Registration) Regulations 2009. Notification of other incidents. How the regulation was not being met: The provider had not notified the commission following the outcome of a Deprivation of Liberty Safeguards application.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 (RA) Regulations 2014 Person-centred care Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care How the regulation was not being met: People needs were not accurately assessed and planned for and they did not consistently receive they care and treatment that was appropriate and met their needs.

The enforcement action we took:
We service a warning notice that the provider must comply with the Regulation by 29 January 2016.

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and treatment How the regulation was not being met: There were shortfalls in: risk management, the staff's skills and experience to provide safe care and medicines management.

The enforcement action we took:
We service a warning notice that the provider must comply with the Regulation by 29 January 2016.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance

This section is primarily information for the provider

Enforcement actions

How the regulation was not being met:

There were shortfalls in the governance, management of risks, record keeping, acting on feedback from relevant persons and the lack of improvement planning.

The enforcement action we took:

We service a warning notice that the provider must comply with the Regulation by 29 January 2016.