Salutem LD BidCo IV Limited

Godfrey Olsen House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service: Godfrey Olsen House is a residential care home that was providing personal care to 6 people at the time of the inspection.

People's experience of using this service:
People had not always been kept safe. A fire risk assessment in August 2018 had actions that had not been completed in May 2019 when we inspected. This was in part due to the property being owned by a housing trust who were responsible for maintaining the building, however the responsibility for the safety of the premises was the provider's therefore this is a breach of the Regulations.

We found that practice around medicines management had not always been safe. Temperatures, storage and audits were not effectively managed. This was a breach of the Regulations.
Oversight of the service and audits were not effective. This was a breach of the Regulations.

Staff told us that staffing levels were not sufficient to provide good care. They had to focus on tasks such as moving and assisting and medicines when lone working, which was a frequent occurrence, and less time sensitive tasks such as cleaning were handed over to the next shift. If the afternoon shift staff were also lone working, then cleaning may not be completed at all. This impacted on people's experience of care and cleanliness of their home.

Staff told us, and records supported that supervisions or 1-1 meetings had become less frequent. The provider was not meeting their number of supervisions per year as stated in their policy.

People were supported to access healthcare services and support groups relevant to their health conditions. The provider had good working relationships with local commissioners and the health trust.

We saw that keys to each flat had been hung in the entrance area to the home so the flats could be accessed by staff in the event of an emergency. We asked for them to be moved to a more secure location to minimise the risks to people's security.

People could choose to be involved with developing their care plan if they wished however some people preferred not to be involved.

Staff were kind and caring and we saw interactions that showed people had positive and appropriate relationships with staff members. People enjoyed the company of staff.

People were supported to maintain their independence and to live their lives as they wanted. Staff understood the principles of the Mental Capacity Act and told us they would support people with their decisions, even if these were deemed to be unwise decisions.

Audits were regularly completed however these were not always sufficiently robust. For example, an audit of care plans had found them to be reviewed and current, however we found that not all documents were dated and could not be sure if they had been reviewed.

Godfrey Olsen House met the characteristics of Requires Improvement in most areas. More information is in the full report.
Rating at last inspection: Godfrey Olsen House changed provider in April 2018. Their rating under the previous provider was good; last report published on 20 January 2016.

Why we inspected: This was a scheduled inspection based on this having been registered under a new provider in April 2018.

Follow up: We have asked the provider to develop an action plan to improve the rating of the service to at least Good. We will continue to monitor the service and will re-inspect as per our schedule for services rated as 'Requires Improvement'.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was not always well-led Details are in our Well-Led findings below.	**Requires Improvement**

Godfrey Olsen House

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of two adult social care inspectors.

Service and service type:
Godfrey Olsen House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
Godfrey Olsen House provides accommodation for up to six people with disabilities in two, two-bedroom flats and two bedsits. When we inspected, six people were receiving care at the service.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was unannounced, we gave no notice of our inspection.

What we did:
Before we inspected Godfrey Olsen House we looked at the information we already held about the service. We reviewed the Provider Information Return (PIR). The provider completes this at least once every year to tell us what the service is doing well and about any plans to improve. We looked at notifications. Notifications are sent to us by the service to tell us about significant events.
During our inspection we spoke with the registered manager, a team leader, three support workers and six people who lived in the service.
We saw records concerning the premises, recruitment files for three staff members and three care records.

Requires Improvement

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Systems and processes to safeguard people from the risk of abuse
• Staff participated in annual training in safeguarding adults and children. When we spoke with staff they had good understanding of the signs and symptoms they may see should someone be experiencing abuse.
• There was information about whistleblowing in the office and staff told us they would not hesitate to report concerns outside of their organisation if they believed they had not been appropriately dealt with.
• People told us they felt safe living in the service. One person said, "I feel safe here, I'll be happy living here for now".

Assessing risk, safety monitoring and management; Preventing and controlling infection
• The provider had a range of checks that were regularly completed to ensure safety in the service. These included a legionella risk assessment and regular checks of water temperature, servicing of equipment such as hoists, and a fire risk assessment completed by an outside contractor to ascertain whether the premises would be safe should fire break out.
• The fire risk assessment had been completed in August 2018 and had identified several concerns including compartment breaches, combustible materials stored in electrical cupboards and inappropriate materials being used to seal voids. One door of a flat had a gap of more than four millimetres and in addition did not latch meaning there was no barrier against smoke and fumes should fire break out.
• When we visited the service in May 2019 we found that several of the works that had been categorised as high priority in the fire risk assessment had yet to be completed. Works were booked in during the two weeks following our inspection. For up to eight months, compartment breaches and a door which did not latch had not been fixed leaving people at risk of serious harm should a fire break out. In addition, Combustible materials remained stored in the electrical cupboard. The registered manager had requested that the works be completed however due to the premises being owned by a housing association, maintenance was completed when arranged by the owned and not when requested by the provider.
• Staff had been trained in infection prevention and control and were aware of when and how to use personal protective equipment to minimise the possibility of infection.
• A cleaning schedule was in place; however, we saw that tasks were not completed daily and were not prioritised due to staffing levels. One staff member told us, "In the morning I prioritise getting everyone up safely and medicines and moving and handling [assisting]…. I leave washing up and cleaning etc. Medicines are important, and we need to give people structure to their day". Tasks would be handed over to staff members on the next shift, however we saw this did not necessarily mean that they would be completed. Cleaning schedules reflected that cleaning was not always completed.
• People's flats had not been thoroughly cleaned, for example, floors had not been vacuumed and the cooker and microwave in one flat were not clean. The gardens and lawns were overgrown with litter lying on the ground. The team leader told us they hadn't had time to tidy up the gardens.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Premises and Equipment.
• We saw risk assessments in care files that referred to, for example, medicines, food and drink, bed safety and finances. These had not identified specific risks but were set out as support plans.
• One person's risk assessment for eating and drinking referred to their choking risk assessment. We looked for this, but it had not been completed. We were told "It's on my list of risk assessments to do. I can knock them up in half an hour". The choking assessment was then found on the computer and stated there was no risk. We recommend reviewing the risk assessment proforma to ensure that in future, hazards are identified, and mitigating actions shown on the assessments.

Staffing and recruitment
• Staff were safely recruited and before commencing working for the provider supplied two references and a full employment history. Peoples recruitment files contained application forms, interview notes, proof of identity and proof of any qualifications. A Disclosure and Barring Service (DBS) check was completed before staff commenced in post. The DBS check enables employers to make safer recruitment decisions and prevents unsuitable staff from working with vulnerable people.
• Staff told us there were not always sufficient staff deployed. Staffing levels should be two staff on duty during the morning and afternoon shifts and one waking night staff member. Frequently staff were lone working during both the morning and afternoon shifts due to lack of available cover. The provider used agency staff to cover some shifts however staff told us there was often no cover during the day.
• One staff member told us, "Staffing levels are not always sufficient. There is a lot of lone working, but it has improved lately, they try hard to keep staffing levels up. Lone working is manageable but is not necessarily the best care".
• Recruitment had recently taken place and additional staff would be commencing in post soon. However, until that happened, staff lone working during busy shifts told us they prioritised tasks such as moving and assisting and medicines and handed over other tasks, such as cleaning, to the next shift.

Using medicines safely
• Staff received training in administering medicines. People told us they were given their medicines when they went and asked staff for them. There was no specific timing of medicine rounds in place at the service. One person told us they would prefer to have control of their own medicines. They said, "They [staff] come in and give me my tablets, I would rather do it myself as it isn't always on time and I have to go and ask for it". They continued, "It (medicines) has to be every four hours and the last is at 9:00 pm. They wouldn't give it until 9:30pm so I had to stay up and wait". Another person told us, "Staff do medication and when I ask for them they always give them to me. They always get them right as they come in little boxes".
• The administering of medicines should be reviewed as having to ask for medicines is not empowering for people, consideration should be given to a times medicines round or people self-medicating if able.
• People had PRN or as required medicines such as pain killers available for use when needed. There were no PRN protocols in place when we inspected. Following the inspection, we were supplied with protocols for each person that needed one. These contained minimal information and referred to prescription and medicine administration records, MAR. Information on what conditions the medicines were for, the dosage and possible symptoms had not been included in the protocols.
• Medicines were ordered pre-packaged in monitored dose systems, (MDS). One week's supply of medicines were stored in individual medicine cabinets in people's flats. Additional stocks of medicines, including weekly MDS packs, were stored in a locked cupboard in the service and there was a second medicines cabinet in a room off the staff office containing PRN medicines and controlled medicines. The room was originally a bathroom, the shower had been disconnected however the toilet remained connected but not in use.
• The medicine cabinet was sited above the toilet. We asked for reassurances that the toilet was not in use as

this could pose an infection control risk due to the medicine's storage. Following our inspection, the registered manager supplied us with photographic evidence that the toilet was not in use. A table had been placed across the pan and the seat and lid were taped closed. They also advised that flushing the toilet had been added to the water hygiene schedule of flushing infrequently used outlets.
• Temperatures were recorded daily in all medicine cabinets in the service. During warmer weather, cabinets in people's flats had become too warm, above the recommended 25° Celsius. Medicines were transferred to the central cabinet, however the temperatures in the main cabinet also exceeded 25° Celsius at times. When this happened, cool packs were added to the cabinet to ensure that the temperature remain at a safe level.
• Medicines were audited, and we noted that the checks around controlled medicines had not been completed. When we inspected there was one, schedule three controlled drug stored. This was recorded in the controlled drugs log however not audited as to whether the correct amounts were present or that two people had signed for it. The audit also checked that cabinet temperatures had been taken twice daily however did not check for actions if the temperatures exceeded recommended levels.
This is a breach of Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the proper and safe management of medicines;

Learning lessons when things go wrong
• Incidents were documented and learning from them shared with the team. Information was shared using a communication book.
• The provider ensured that all accidents, incidents and complaints were recorded, investigated and actions taken to minimise future occurrences.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People were assessed by the provider before moving to Godfrey Olsen House to ensure their needs could be met by the service. Assessments were shared with staff before the person moved to the home but were not included in care files. The assessments were not considered to be essential for staff to access apart from as part of the admission process and copies were retained electronically. We suggested that assessments should be added to care files so that staff had more understanding of peoples care needs.
• Staff were able to read people's care files before supporting them. However, some night duties were being covered by agency staff. The lack of assessments in people's care records meant the provider could not be assured that agency staff were fully aware of people's conditions and needs before supporting them.
• Care plans and risk assessments seen during our inspection were not dated and as such we could not be sure they were current.

Staff support: induction, training, skills and experience
• Staff completed extensive training courses during their induction and shadowed experienced staff in the service before being added to the rota.
• Training was updated annually and most staff were current with their training at the time of our inspection. Courses included basic life support, communication, food safety, data protection, moving and assisting and medication. Since our inspection, the registered manager has sourced additional training for staff around drug and alcohol abuse with a local NHS support group.
• Staff had allocated supervisors who they met with. Supervisions had become less frequent during the months before our inspection. One staff member told us, "My last supervision was two months ago. (March 2019). The one before that was in June or July last year (2018)". Another staff member said, "[Supervision] is a bit more difficult to have lately because of staffing. When I first started it was about every six weeks but it's not like that lately. I had one about a month ago. I feel supported but through speaking to management not through supervision". A third staff member told us, "We try to do monthly, but it is usually no longer than two months between [supervisions]. We get an email beforehand and you can email back things to add to the agenda".
• This was not in line with the providers policy and procedures which stated, 'Staff should receive a minimum of six supervision sessions each year to help with their personal and professional development, however for inexperienced staff or those with performance issues, supervisions should be held more frequently. For those staff still in their probationary period supervisions should be held monthly'.
• We recommend that supervisions are scheduled so that staff receive their 1-1 support as per the providers policy.

Supporting people to eat and drink enough to maintain a balanced diet
• People who were able to cook for themselves were encouraged to do so and staff prepared meals for others. Temperatures of all meals served were recorded and staff either prepared foods people chose or had indicated they liked.
• People were supported to make healthy food choices and staff had supported people with weight loss diets. One person had prescribed drinks to fortify their diet and increase their calorie intake however usually chose not to have them. Staff respected their choice however continued to offer the supplements.

Staff working with other agencies to provide consistent, effective, timely care
• The provider liaised with other agencies to facilitate effective care for people. People living in the service accessed health support groups, GP surgeries and district nurses as required and in a timely way.
• There were close working relationships with local commissioning teams.
Adapting service, design, decoration to meet people's needs
• The premises consisted of two, two-bedroom flats and two bedsits. People could have their bedrooms or bedsits decorated in their chosen style and individual rooms reflected people likes and dislikes.
• The premises were part of a purpose-built development of flats and had wide corridors and an accessible bathroom. As part of a block of flats, the premises had not been designed as a care home and the staff office had originally been part of a flat. The office space was not accessible to people living in the service and there was limited suitable storage throughout the building for confidential records and medicines for example.
• We saw that keys to each flat were hung in the corridor close to the front door. An entry system meant that only permitted people could access the building however we asked the provider to move the keys to a more secure location, so they could be obtained quickly in an emergency but were not accessible to unauthorised persons. This was completed during our inspection.

Supporting people to live healthier lives, access healthcare services and support
• People accessed their GP's and other medical practitioners, such as hospital outpatients, with support from staff in the service. If people wanted a GP appointment, staff would book this for them and if necessary accompany them to the appointment.

• People in the service were also enabled to attend local support groups relevant to their health conditions. Staff would either accompany them or support them to find and attend meetings to enable informal support from people in similar situations.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• When we inspected the service, people living there had capacity to make decisions and consent to care. This was reflected in their care plans. Consideration was given to people's conditions and staff told us that

some peoples capacity fluctuated and important issues would be discussed at times when the person was most able to understand and make informed decisions.
• The provider understood their responsibility under the MCA and care files reflected this.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• Staff spoke with a genuine fondness for the people they supported. One staff member told us, "I enjoy the people, I love them…. they are all brilliant with their own quirks. I work to help them get better at things like improving their independence, that's what I love".
• We saw positive interactions between staff and people, both when staff were delivering support and generally throughout the inspection. We saw people joking with staff and seeking them out for conversation. One person told us, "They are good to talk to, but hard to find someone to talk to in the afternoons if there is only one person on". They went on to say, "I like to have staff with me in the evenings, they keep me company sometimes".

Supporting people to express their views and be involved in making decisions about their care
• Staff told us they felt that the freedom offered by the service had been beneficial in people feeling settled and at home there. People enjoyed being able to come and go to the local shops, some did this daily.
• The team leader told us they tried to match staff with people when selecting keyworkers. A keyworker is a named member of staff who acts as the main support worker for the person. One person had been supported by a lively and outgoing keyworker. After monitoring the situation, a less outgoing staff member with a quieter approach had begun to work with them. The person had responded well to this and was maintaining their wellbeing more effectively.
• People's care reviews were not always formal meetings involving family and professionals. When people's care plans were reviewed, staff would speak with them as and when they were willing to chat. The team leader told us they would ask people if they were happy with their care and if they wanted anything changed informally, such as when they were out for lunch, as people responded better to this.
• The registered manager and team leaders provided support via an 'on-call' system. This would be used by staff if they needed advice about any situations that arose when there were no management on site. The on-call system was also available to people living in the home. Contact numbers for on-call staff and an indicator of who to call was displayed for people so they could contact management when needed rather than waiting for staff to do so on their behalf or for the managers to be back on duty.
• People were involved in care planning as much as they wanted to be. One person told us, "I've seen my care plan and have given my own ideas about it". Other people did not want to be involved in planning their care.

Respecting and promoting people's privacy, dignity and independence
• People were enabled to live their lives as they wished, and staff supported this. People did not always make wise choices however staff would support them with any consequences.
• People had their own private bedrooms and there were two shared flats with communal areas. However,

due to the needs and wishes of each person, privacy was maintained.
• People were mostly happy with their accommodation, however one person told us that at times they felt they had to stay in their room due to the needs of another person in the service.
• Staff were keen to ensure that people were able to develop skills of independence when needed. People needed various supports with personal care, cooking and other tasks and all were encouraged to do what they were able to do, and staff would then support them with tasks they were less able to complete.
• Care files were stored in people's rooms or in a cupboard in the staff office. Daily care notes were not locked away but stored in easy to access pockets attached to the office walls.
• Staff understood confidentiality and had received training in data protection.

Good

Is the service responsive?

Our findings

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

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• There was no activities programme run at the service. A staff member told us, "We don't provide activities, so if they want to do activities they can access the town and can ask for support to do so. There is a lot to do locally. [Person] has done a lot over the years. There are dance classes, there is a gym, and they go out for meals and coffees. There are not necessarily group sessions like art and crafts".
• Activities were provided on an individual basis as people enjoyed spending time with staff members and needed some support from them when out in the community. Community access and 1-1 support were available when staffing allowed and not usually when staff were lone working. Group sessions would not be possible to arrange as the only large areas in the home were the lounge areas in the two-bedroom flats, both of which were spaces used by the people living in the flats and not communal areas.
• There were occasional group activities including a barbeque that had been well attended by people.
• Some people living in the service were working towards living in a more independent location such as extra care housing or supported living. As such, staff felt that people should be proactive and if interested in doing an activity they should suggest it.
• Peoples care files held information about their families, life history and their interests.

Improving care quality in response to complaints or concerns
• The provider had a complaints procedure and aimed to resolve complaints within a 28-day period.

End of life care and support
• The service was not currently providing end of life support for anyone. End of life care plans were being developed for some people. The age range of people using the service was from people in their thirties to their seventies so if people wanted to consider end of life plans they would be encouraged to do so.

Requires Improvement

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility
• The registered manager was open with the inspection team and transparency was one of the providers core values. The registered manager understood their duty of candour responsibility.
• The provider had changed since our last inspection and the new provider's mission and values were still embedding into day to day practice.
• Person centred care was planned and delivered to people living in the home when staffing allowed. When staff were lone working they could cover basic care tasks, however were not able to support people in accessing the community or with significant periods of one to one support.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The service had a registered manager in post. 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.
• Staff felt supported by the local management team however told us that morale was not always good due to the ongoing lone working.
• Since the change in provider we have not received any notifications from the service.
• Two part time senior support workers completed most day to day management tasks and throughout the inspection the registered manager referred to the team leader frequently for information about the service.
• Audits were completed about aspects of the service on a monthly basis.
• A 'monthly checks' audit was completed to ensure that other audits such as infection control and medicines had been completed and that support plans and other documentation were current and that archiving of records was completed. We saw one monthly check that stated that all support plans and risk assessments were reviewed and current. When reviewing people's care records we had noted that many support plans and risk assessments were not dated so we had been unable to tell if they were current.
• Audits were not effective, actions had not been taken following audits, for example, dates had not been added to reviewed documentation and actions to minimise the risk to medicines from high or low temperatures were not identified. The environment was not well maintained, though action had been taken to alert the owner of the premises of the fire risk assessment, the provider could have mitigated the risk in a timelier way. Other areas of the environment such as the gardens had not been maintained though these were the providers responsibility. PRN protocols supplied did not indicate that there was a clear understanding of their purpose or what information needed to be included. There was limited oversight of

the service, the Provider Information Return, (PIR) did not only reflect the regulated services provided at Godfrey Olsen House but included reference to 12 people receiving regulated services and two sites. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Staff meetings were held every six weeks. Due to shift patterns, not all staff could attend however minutes were taken and shared. We saw minutes that contained reminders about tasks, updates about people's care and information about training.
• There were no group meetings with people about the service. People did not want a forum in which to speak up, so feedback was taken individually as and when given.

Continuous learning and improving care
• The registered manager dealt with concerns such as combustible items stored in an electrical cupboard as we found them. These were immediately removed, and the cupboard labelled to advise staff not to use for storage. This concern had also been dealt with when noted in the fire risk assessment in August 2018, the items shown in the risk assessment photographs were not the same ones that were removed during our inspection. Learning had not been taken from the initial concerns.
• Staff had not received training for all people's needs. Since our inspection, the registered manager has arranged with a local alcohol and substance abuse group for staff to be trained in supporting people with these needs.

Working in partnership with others
• The registered manager had sought training from a local support group they had linked to when seeking support for people living in the service.
• There were close links with commissioners. When we were inspecting there was a social worker on site following up on concerns raised by the service about new behaviours they had noted.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines audits were not fully completed, medicines storage temperatures were not always within safe limits and one of the medicine storage areas did not have a robust lock.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment High priority actions from a fire risk assessment were not acted upon for over nine months resulting in people's risk of harm should a fire break out being increased.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits were not effective, there was a lack of oversight of the service and risks to people from the environment had not been mitigated in a timely manner.