Westgate House Limited

Westgate House

Inspection report

Eastcote Road
Gayton
Northampton
Northamptonshire
NN7 3HQ

Tel: 01604859355
Website: www.westgatehousenursing.co.uk

Date of inspection visit:
14 July 2021

Date of publication:
17 September 2021

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Westgate House is a care home that is registered to provide accommodation and personal care for up to 44 older people including people living with dementia. At the time of inspection 35 people were using the service.

People's experience of using this service and what we found
People were not consistently protected from harm. Physical interventions were not recorded appropriately, and unexplained injuries were not always investigated to identify a cause. Not all safeguarding's had been notified to the relevant professionals.

Risk assessments were not always in place or contained enough information. Staff did not always have the information required to support people safely. Some care plans held conflicting information and some care plans had missing information.

People's care was not reliably recorded. We found gaps in the recording of repositioning charts, oral care, food, fluids, cleaning and incident forms. This meant we were not assured tasks had been completed.

Medicine administration required improvement. People were at risk of not receiving their medicines as prescribed. Staff did not always record they had given people their medicines or explained why they had given 'as required' medicines or their effects.

The environment required attention. The home appeared dirty with stains on walls, floors and furniture. We found damaged furniture. Cleaning records had gaps in the recording.

Improvements were needed to promote people's independence, dignity and respect. We observed limited positive interactions between people and staff. Activities were limited and people stayed in one communal area for the day.

People's communication needs required further development. We found people who required specific communication aids, did not always have this need met.

Systems and processes to ensure oversight of service required improvement. We found limited governance systems to ensure care was delivered, and records were kept and maintained. Policies and procedures were not always followed.

Lessons learnt and improvement of the service was lacking. Feedback from staff, people and relatives had not been sought to improve and monitor the service. Trends and patterns were not always reviewed and shared.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff were recruited safety and completed an induction, training and shadow shift before starting work. However, not all staff had received refresher training.

People were supported to access healthcare. Referrals were made to external professionals such as speech and language therapists, dieticians and GP's.

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

Rating at last inspection and update.
The last rating for this service was requires improvement (published 4 May 2020) and there was one breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about cleanliness, oversight, records and safeguarding. A decision was made for us to inspect and examine those risks.

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

We have found evidence that the provider needs to make improvement.

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

We have identified breaches in relation to risks, recording, safeguarding, oversight, food and hydration and person-centred care at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

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 not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Westgate 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
This inspection was completed by two inspectors.

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

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
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this

report.

During the inspection
We spoke four relatives about their experience of the care provided. We spoke with eight members of staff including the provider, registered manager, and care workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure systems and processes were sufficient to ensure people were safeguarded from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had not made improvements and was still in breach of regulation.

- Records of restraint were not completed in line with the providers policies or best practice. For example, we found records that evidenced five staff were required to support one person with personal care, there was no record of what restraint techniques had been used, who the staff were and if a less restricted option had been considered. This put people at risk of inappropriate treatment.
- Not all care files had the information of what restraint techniques could be used with a person as per the providers policy and best practice guidance. Staff told us, they often held people's hands down to stop them hitting others or staff. We found this information had not been recorded in care files and staff confirmed this information was not consistently recorded; staff were not following the provider's policy.
- Staff told us they did not receive a debrief after any incident of restraint was used. We found no records of debriefs recorded.
- When people received an injury, such as a bruise or a skin tear, records were not always completed. This meant that staff could not always assess if an injury was improving or if additional healthcare support was needed.This also meant the registered manager had not investigated the cause of the injury to determine if actions were needed to safeguard the person.
- The provider had not submitted safeguarding referrals appropriately to ensure people were protected from harm. For example, where we found records that evidenced people had been harmed, the registered manager did not provide evidence of safeguarding notifications being submitted to the local authority. We shared this information with the local commissioners.

The provider had failed to ensure systems and processes were in place and followed to ensure people were protected from abuse and improper treatment. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had safeguarding policies and procedures in place, these were accessible to staff. However, they had not consistently been followed.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

● People were at risk of pressure damage. We found people who required time specific repositioning did not have this need recorded. For example, we found gaps in multiple records that indicated people had not received their pressure area care for many hours after their prescribed repositioning times. Therefore, we could not be assured that this need had been met.

● Strategies recorded to mitigate known risks were not consistently followed. For example, we found gaps in the recording of blood sugar monitoring and continence checks. This put people at risk from their known health conditions.

● Not all risk assessments were in place. For example, one person who had previously choked did not have a choking risk assessment in place. Another person who had suffered injuries from a hoist sling did not have a risk assessment in place and was still using a sling. This put people at risk of harm from known risks.

● Risk assessments in place did not always contain sufficient information to mitigate the risks. For example, risk assessments for people's behaviour that challenged did not always contain the strategies that should be used to mitigate the risks. This put people at risk of inappropriate physical interventions as staff did not have the information to keep themselves and other people safe.

● People were at risk of infection from an unclean environment. We found areas of the home were dirty, clean medicine pots had been left on a dirty radiator and rips in chairs and sofas meant effective cleaning could not be completed.

● People were at risk of not receiving their prescribed medicines. Medicine administration records (MAR) showed staff had not always signed to evidence a medicine had been administered. Therefore, we could not be assured that people had received their medicines as prescribed.

● Staff did not always have the information they needed to administer 'as required' (PRN) medicines. We found not all PRN medicines had protocols in place to identify the reason the medicine could be given. Staff also, did not consistently record the reasons a PRN medicine was given. This put people at risk of not receiving their medicines for the reasons they were prescribed for.

● The provider did not analyse accidents and incidents for trends and patterns. This meant lessons were not learnt when an incident or accident occurred, information was not shared with staff and improvements that could be made were not identified.

The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. The provider had failed to ensure the proper and safe management of medicines. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Cleaning schedules had gaps in the recording.

● We were not fully assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were not fully assured that the provider was using PPE effectively and safely. We observed one staff member did not wear their personal protective equipment (PPE) correctly

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

● We were assured that the provider was meeting shielding and social distancing rules.

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

● We were assured that the provider was accessing testing for people using the service and staff.

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

● We were assured the provider was facilitating visits for people living in the home in accordance with the

current guidance.

Staffing and recruitment

● We could not be assured that sufficient staff were being allocated. Not all staff felt there were enough staff on duty every day. We were told, "At times we don't have enough staff to sit and talk to people" and "Some residents need [a number] of staff and others need one to one. When things happen, we don't have enough [staff]."

● The provider had identified the required number of staff needed. The rota evidenced that on average there were eight care staff and two nurses on each shift. However, due to the needs of the people living at Westgate, at times due to situations, this was not enough.

● People were protected against the employment of unsuitable staff. Records confirmed that Disclosure and Barring Service (DBS) checks were completed and references obtained. These are checks to make sure that potential employees are suitable to be working in care.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- People were at risk of dehydration. Three people who had been identified as at risk of dehydration required regular and close monitoring of their fluid intake. However, they did not have their fluids adequately monitored as there were gaps in the recording and their charts showed these people did not reach their fluid target on numerous occasions.
- People were at risk of malnutrition. One person who had been identified as at high risk of malnutrition required additional food supplements in line with a dietitian's recommendations. They required additional milkshakes and high calorie snacks to be given daily, these had not been recorded as given. Two other people's records did not evidence they were offered food for every meal.
- Care plans did not always contain the correct information regarding fluid consistency. Staff did not have reliable information on how to give fluids safely, placing people at risk of choking. For example, one person's care plan had conflicting information recorded regarding the consistently required for their fluids.

The provider had failed to ensure the nutritional and hydration needs of people was met. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Not all staff had received updated training. The training matrix evidenced that all staff had not completed training in infection control, equality and diversity, dementia, first aid and safeguarding. However, staff told us they were 'allocated' online training courses and were happy with the training offered.
- Staff told us they did not receive regular supervisions. One staff member said, "I have never received a supervision." Another staff member told us, "I had one years ago, but not recently." The registered manager was unable to demonstrate that staff had regular supervision sessions. The supervision matrix did not match up with what staff had told us. For example, the matrix showed a staff member had received supervision on a set date however, the staff member stated they had not received a supervision.
- Staff received an induction and completed shadow shifts on starting with the service.

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 when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, 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 , and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The provider had not always followed best practice and guidance on completing mental capacity assessments. For example, we found one person's capacity assessment stated they lacked capacity, however the judgement was linked to them being non-English speaking. We found no evidence the provider had supported the person by use of an interpreter or other methods enable communication fully.
● The registered manager had submitted DoLs applications appropriately.

We recommend the provider reviews all capacity assessments to ensure all that is practical, has been done to support people to understand information and make their own decisions and to ensure people have an advocate when required.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's oral health care needs were assessed, and care plans detailed what support a person needed and how staff should meet this need. However, records evidenced that three people who required support did not have this need met. This put people at risk from dental issues.
● Staff did not always have the required information to support people in line with their individual needs. Not all care plans held up to date relevant information in them. For example, what interventions should be used or what equipment they used to maintain their safety.
● People's needs were assessed before they moved into the home to ensure these could be met.

Adapting service, design, decoration to meet people's needs
● Areas of the home required improvement. Some furniture was damaged, and some walls were stained.
● Areas of the home had signage in place, to help people navigate the building.
● The provider had ensured radiators were covered and windows had restrictors on them to maintain people's safety.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People received support from health care professionals as and when needed, such as GPs, speech and language therapists and dietitians.
● Relevant health information regarding people was recorded in their care records.
● Staff knew what action to take in an event of an incident or emergency.

Requires Improvement

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement; This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People's equality and diversity was not always respected. We found one person who did not speak English had limited opportunities to communicate. The registered manager told us that only two staff could speak the person's native language. The registered manager was unable to provide evidence that showed they had supported the person's communication, such as information in their native language or pictures/symbols used to aid communication.
- People's dignity was not always respected. We observed a person sat in the communal area throughout the inspection next to a bin. The bin was in use and at times became full.
- Some staff appeared kind and caring. However, the provider's systems and processes did not always support person centred care and risks had not all been mitigated to ensure people were safe.

Supporting people to express their views and be involved in making decisions about their care

- We found no evidence of people being asked for or consenting to staff sharing information about them to significant people.
- Staff told us they always asked a person for consent before completing any personal care tasks, knocked on doors before entering and ask their preferences. We observed staff knocking on doors and asking permission to enter.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their
carers.

● People's communication needs were not always met. For example, one person's care plan stated they may rely on lip reading, however, we found no adaptions or strategies implemented for when staff were wearing face masks. Another person's care plan stated they used pictures for communication. However, we found no evidence of these being used. The registered manager stated they did not have any information in easy read, pictorial or large print. This meant people did not always have the opportunity to have the information they needed to understand their care choices.
● Care plans did not always contain person centred or factual information within them. For example, we found one person's care plan stated they used bed rails; the registered manager told us this was incorrect. Another person's care plan stated their pressure mattress should be set at 50kg when they weighed over 65kg. People were at risk of not receiving care that met their needs as staff did not have accurate information.
● We observed that staff did not always engage people in activities or respond appropriately to them. We completed a Short Observational Framework for Inspection (SOFI) during the inspection and observed that when people called for staff they were often ignored. We saw no activities being offered. Staff told us, "We don't have the staff to do activities." This meant people did not have the opportunity to have their social and emotional needs met.
● People did not always have choices and control. We observed people sat on their (hoist) slings, the provider told us this was "to save time as we don't have to take them off, and it is easier for staff." A staff member told us, "We leave slings on as we wouldn't know what to do if we had to keep putting them on and off." This meant staff carried out task orientated care, not taking into account people's individual needs and preferences.
● People's independence was not always supported. One person said, "They [staff] put you to bed at 7.30-8pm its ridiculous." A staff member told us, "We start putting residents to bed at 7pm, so we can get everything done."

The provider had failed to ensure the care and treatment of people was appropriate, met their needs and reflected people's preferences. This was a breach of regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● The registered manager told us they had not received any complaints. The provider had policies and procedures in place regarding how complaints should be responded to.

● Relatives and staff told us they knew how to complain. One relative said, "If there is any issue it is always dealt with." A staff member stated, "I haven't complained but I know I could if needed."

End of life care and support

● At the time of our inspection, no one using the service required end of life support. However, when appropriate, people had a 'do not attempt cardiopulmonary resuscitation' [DNACPR] order in place.

● Some details were recorded regarding a person's wishes after death. However, we found limited information regarding information for end of life care. For example, who would be there, if they wanted any music or sounds playing or if they if they wanted a priest or minister to deliver their last rites.

Inadequate

Is the service well-led?

Our findings

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

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider lacked oversight of the service. We found no provider audits being completed to ensure the registered manager followed policies and procedures.
- Systems and processes to ensure hygiene standards were in place, were ineffective. We found gaps in the cleaning schedules, the home appeared dirty, furniture was damaged and high touch cleaning was only recorded as carried out once a day. People were at increased risk of infection.
- The provider had not identified when risks to people had not been mitigated. We found no action plan or audit that had identified when strategies to reduce risks had not been completed. For example, choking and pressure damage. This people at increased risk of harm from known risks.
- The provider had not identified the incorrect or missing information we found in people's care files. For example, mobility needs, fluid consistency, mattress settings and interventions used. People were at risk of falls, pressure ulcers and choking.
- The provider had not identified or put actions into place when daily records of care were missing. For example, food and fluid charts, oral care records, repositioning tasks and bowel movements. People were placed at risks associated with dehydration, malnutrition and constipation.
- Systems and processes to ensure people were protected from harm were not always effective. For example, when unexplained bruising had been recorded without a cause, this had not been identified to ensure an investigation could be completed. This put people at risk of abuse.
- Audits had not been completed on physical interventions. We found information was missing and incident forms had not been reviewed by a manager. The registered manager had not followed the providers policy on the recording and monitoring of physical intervention. As a result, people were placed at risk of injuries and inappropriate restraint techniques.
- Medicine audits were ineffective. The audit completed had not identified missing signatures, or when protocols were not in place. People were at risk of the effects of not receiving their medicines as prescribed.
- The provider did not send out surveys or gain feedback from people using the service. Relatives told us they had not been asked to feedback on the service. The provider failed to use people's feedback to evaluate and improve the service.

The provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a breach of Regulation 17 (2)(a) (good

Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives told us; they were not involved in the care planning for their loved one. However, they were kept up to date by staff if any changes occurred to their relatives. Newsletters were sent to families with general service updates.
● Staff told us the management had an 'open door.' One staff member said, "I can speak to [registered manager] and I think they would take my views into consideration."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
●The registered manager was aware of their duty of candour responsibility and had systems in place to ensure compliance.
● Staff knew how to whistle-blow and knew how to raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns were not acted upon.

Continuous learning and improving care; Working in partnership with others
● The management team worked in partnership with other health and social care professionals.
● The registered manager was working with commissioners to implement improvements and to formulate an action plan.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure the care and treatment of people was appropriate, met their needs and reflected people's preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure the nutritional and hydration needs of people were met.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. The provider had failed to ensure the proper and safe management of medicines.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure systems and processes were sufficient to ensure people were safeguarded from abuse and improper treatment

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided.

The enforcement action we took:

Warning Notice