Cornwall Care Limited

St Martin's

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

Overall summary

This unannounced inspection took place on 24 February 2015.

St Martins provides nursing care and support to predominately older people who have a diagnosis of dementia. The service can accommodate up to a maximum of 40 people. There were 37 people living at St Martins when we inspected the service. Some of the people at the time of our visit had mental frailty due to a diagnosis of dementia or other mental health conditions.

The service had a manager registered 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 and associated Regulations about how the service is run.

When we inspected the service in August 2014 we found breaches of legal requirements relating to the safe management of medicines and the assessing and monitoring of the quality of the service. This was because the management of medicines at St Martins did not protect people from potential risk. Quality assurance

Summary of findings

tools were used, but when issues were identified action or a change in practice was not evident. People who used the service and their representatives were not asked for their views about their care and treatment. Care plans did not show people's involvement in their care.

The provider responded by sending the Care Quality Commission (CQC) an action plan of how they were addressing the breaches identified.

The way medicines were being managed had improved since the inspection of the service in August 2014. However, records were not always accurate. Some medicines which had been administered had not been recorded. There was an occasion when 0ne person could not have prescribed medicine because the time for administration of the next dosage was too close to the previous.

Records reporting on people's healthcare and any identified risks were being completed and regularly updated. However, in one instance we saw that where a person's nutritional and hydration needs had needed to be monitored, there were gaps in their records. Where meals were refused over a four day period, there was no evidence as to what action had been taken. The person's fluid intake was not being recorded regularly as instructed in the care plan. There were no calculations taking place to measure what amounts of fluid the person had received each day.

The inspection of August 2014 identified the service was not responding to issues identified during its internal audit process. During this inspection we found regular internal audits were taking place. However, the service had not responded to areas identified including, records not being completed in relation to peoples' care and treatment. A sample of food and fluid charts had not been completed in full. Not all records recording people's weights had been completed. Although the issues had been identified during this audit, the same issues were then found during this inspection.

There was evidence the service had responded to complaints raised in a timely manner and recorded what action had been taken in order to identify any trends or themes. However, information informing people how to raise complaints or concerns was not readily available. People told us they would approach the manager but they did not have any formal information to follow. Two recent complaints had been raised verbally with the registered manager who had addressed the issues and informed people of the outcome.

Improvements had been made in the way the service was being staffed. More permanent staff with an appropriate mix of skills had been employed to work in the service. This had reduced the reliance on agency staff. Staff told us this had meant there was more continuity in how care and support was being delivered.

Staff recruitment records showed all relevant recruitment checks were in place which helped to ensure that staff were suitable and safe to work in a care environment. Where nurses were being employed professional registration checks were taking place to ensure they were safe to practice.

Staff told us they received support to carry out their role from senior staff and the registered manager, however formal supervision was not offered regularly. Supervision is a vital tool used between an employer and an employee to capture working practices. It is an opportunity to discuss on-going training and development. The service's own audit had identified supervision was not taking place. The registered manager showed us evidence this had been recognised and a plan put in place to begin the process.

Suitable arrangements were in place to protect people from abuse and unsafe care. Staff understood their responsibilities to report unsafe care or abusive practices.

Steps had been taken to carry out mental capacity assessments and best interest decisions were being recorded where necessary The registered manager demonstrated an understanding of the legislation as laid down by the Mental Capacity Act (MCA) and the associated Deprivation of Liberty Safeguards (DOLS). Staff understood what was meant by restrictive practice in respect of depriving somebody of their liberty.

People told us they felt well cared for living at St Martins and that staff were kind and compassionate. Visitors told us, "We have noticed the staff with other residents. They speak in a caring and respectful way. We don't have to worry about (our relatives) care and safety".

Staff and visitors told us they were being informed of changes occurring in the management of the service.

Summary of findings

They told us they felt listened to and involved in the development of the service. Regular staff and relatives meetings were taking place to ensure communication was effective and people had the opportunity to share their views about the running of the service.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the end of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe:

People were not always receiving their medication at the prescribed times and the medication administration system was not fully operating safely.

Systems were in place to protect people from abuse.

People were protected from the risk of infection.

Requires Improvement

Is the service effective?
The service was not effective:

People's health needs were not being effectively managed.

Staff were not receiving regular supervision or appraisal for development in their roles.

People were supported by staff who had access to training to develop their knowledge and skills.

Requires Improvement

Is the service caring?
The service was caring:

People told us they felt the staff were very caring and respectful when they or their relatives received support.

Staff understood how to protect people's privacy and dignity.

Staff knew the people they were caring for well and communicated with them sensitively.

Good

Is the service responsive?
The service was not always responsive:

People had limited information made available to inform them about how to raise concerns or complaints.

Activities were taking place and people were taking part in small group activities.

People were involved in their care planning and review where possible.

Good

Is the service well-led?
The service was not always being well led:

The service was not acting on issues identified through its own audit processes.

Requires Improvement

Summary of findings

The provider was continuing to develop systems to demonstrate how the views of people using the service were listened to and acted upon.

The registered manager was open transparent and approachable.

St Martin's

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 24 February 2015 and was unannounced.

The inspection team consisted of an inspector, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of services supporting people who required care, due to age related needs and those with a diagnosis of dementia.

Prior to the inspection, we reviewed information we held about the home. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with a range of people about the service. They included seven people who lived at St Martins, four visiting family members, two visiting health professionals and six staff members. We spoke with the registered manager of the service during the course of the inspection. We also spoke with the commissioning authority in order to gain a balanced overview of what people who used the service experienced.

During our inspection we used an observation method called the Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with the people in their care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spent time looking at records, which included, three people's care records, three training and recruitment records and records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

When we undertook an inspection of the service in August 2014 we found prescribed medicines were not always being recorded accurately. Medicines were not always being administered at the times they were prescribed to be given. Records were not being kept to measure the daily temperature of the fridge where medicines requiring specific temperature control were stored. During this inspection we checked to see what actions had been taken to improve the management of medicines.

We found that the management of medicines had improved since our previous inspection. However there were still occasions where it was not recorded whether a dose of a regularly prescribed medicine had been given or not. We found that two people had a dose of medicine left in their blister packs, but these doses had been signed as given on their records. We found two people's charts where it was not clear what had been given or was due to be given, due to crossings out or unclear directions being written on the chart. We found that the morning medicine round was not finished until after 11am. This meant that two people who were prescribed an antibiotic and two other medicines requiring a dose in the morning and again at lunchtime, did not receive their first dose until 11am. The lunchtime rounds were then started at 12.45pm, leading to a risk that people may not have their medicines evenly spaced through the day. We saw from one person's medicine chart that they had previously had to miss a dose of antibiotic as it had been too close to the previous dose. This showed that people may not receive their medicines in the way prescribed to them.

We found that the registered person had not ensured safe and effective systems were in place to manage medicines. This was a continuing breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had changed pharmacy supplier and had been working to improve the way medicines were given and handled. We found that medicines were stored safely and securely. There was a refrigerator for medicines needing cold storage. The temperature of the refrigerator and storage room were now being monitored to make sure medicines were stored in the recommended way, so they would be safe and effective for people. We watched how some medicines were given to people at lunchtime and saw that they were given in a safe way. People were asked if they needed any medicines prescribed to be taken when necessary, for example pain killers.

The home had policies and procedures in place for dealing with allegations of abuse. Staff we spoke with told us they had completed safeguarding training and the training records we looked at confirmed this. Staff were confident concerns would be responded to if reported. Two safeguarding concerns had been reported and investigated. Both instances had involved allegations against agency staff working in the service. The service had taken action to inform the agency staff employer and had stopped these staff members working in the service. We spoke with the registered manager about the impact of using agency staff. The staff were trained and supervised in house to help ensure people were protected.

We looked at how the service was being staffed. We did this to make sure there were enough staff on duty at all times, to support people who lived at the service. We had received concerns that the use of agency staff was excessive and that this had been having an impact on how care and support was being delivered because agency staff did not always know the needs of people living at the service.

We looked at staff rotas and spoke with the registered manager about staffing arrangements. They showed there had been an active recruitment campaign in the previous three month period. This had resulted in one senior nurse and staff nurse being employed as well as a number of care staff. The vacancy list had been reduced significantly between January and February 2015. A staff member told us, "It's been a really difficult time but more staff are working permanently now". Staffing rotas showed there had been a reduction of agency nurses. However some agency staff continued to cover shifts for the two week period 25 January and 15 February 2015. A concern had been raised that there was little consistency in the staff team. Whilst this had been addressed to some degree during the day time period the use of agency staff at night had the potential to limit the consistency of staffing as a whole. The registered manager told us the recent

Requires Improvement

Is the service safe?

recruitment process had targeted day shifts to ensure there was a consistent level of staff to meet people's care and support needs. It was also the intention of the service provider to improve permanent staffing on night duty.

Risks were identified and assessments of how risks could be minimised were recorded. These assessments included; how staff should support people when using equipment, reducing the risks of falls, the use of bed rails and reducing the risk of pressure ulcers. Where people could display behaviour which challenged the service, we saw evidence in care records that assessments and risk management plans were in place. Staff were aware of individual plans and said they felt able to provide suitable care and support, whilst respecting people's dignity and protecting their rights. However, an incident had been reported where staff had not ensured the dignity of a person while experiencing a medical event. The registered manager told us they had learnt from this incident and now had screens to be used when such instances occurred.

Prior to staff commencing work at the service they completed a recruitment process to help ensure they had the appropriate skills and knowledge required to provide care to meet people's needs. We looked at the recruitment files for two staff members and found all relevant recruitment checks were in place to show staff were suitable and safe to work in a care environment. Where nurses were being employed professional registration checks were taking place to ensure they were safe to practice.

There was suitable protective equipment for staff including disposable aprons and gloves. Cleaning schedules were in place and up to date. The lead housekeeper showed us records were maintained to monitor the cleanliness of the service and to help ensure it was a hygienic environment. The registered manager had notified the commission of a recent viral outbreak. Records showed the service had acted appropriately to manage the outbreak safely and ensure restrictions on visitors were in place to protect people from the risk of infection.

Requires Improvement

Is the service effective?

Our findings

Care plans contained detailed information about people's health and social needs as well as a nutritional risk assessment. We noted people who were at risk of losing weight and becoming malnourished were provided with meals with a higher calorific value and fortified drinks. However, in one instance a person's care plan identified a significant period of weight loss. This had been recorded and staff advised to complete daily nutritional and hydration records. Their records noted that meals were refused over a four day period; and in addition fluid intake was not being recorded regularly as instructed in their care plan. There were no calculations taking place to measure what amounts of fluid the person had taken each day. The records did not show what action had been taken to refer this person to other health professionals, where there had been concerns about their dietary intake. The issue was brought to the attention of the registered manager who took immediate action to remedy the issue. The service's own audit for December 2014 had also identified instances where nutrition and hydration charts had not been completed in full. This showed the service was not effectively monitoring people's clinical need effectively. Other records we saw recorded all aspects of the health needs and risk management for people. The records were complete and up to date.

We found the registered person was not effectively monitoring people's needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009, which corresponds to Regulation 9 (3)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records confirmed people had access to health care professionals to meet their specific needs. This included staff arranging for opticians, chiropodists and community nurses. People and visitors told us they were confident that a doctor, or other health professional, would be called if necessary. The registered manager and staff had regular contact with visiting health professionals to ensure people were able to access specialist support and guidance when needed. Records we looked at identified when health professionals had visited people and what action had been taken.

Staff told us they received support to carry out their role from senior staff and the registered manager, however formal supervision was not offered regularly. Supervision is a vital tool used between an employer and an employee to capture working practices. It is an opportunity to discuss on-going training and development. The services own audit had identified supervision was not taking place. The registered manager showed us evidence this had been recognised and a plan put in place to begin the process.

There was a training and development programme in place for staff, which helped ensure they had the skills and knowledge to provide safe and effective care for people who lived at the home. Staff completed the induction when they commenced employment. There was an opportunity for staff to become familiar with the policies and procedures used at the home. A staff member was shadowing an experienced member of staff before they started to work on their own. Staff told us they found this support useful.

There were a number of dining areas available to people using the service. We observed people using dining areas situated in various parts of the service during the breakfast and lunchtime periods. The main dining area was bright, spacious and the tables were laid with linen, napkins and flowers. Staff were available to assist people with their meals when required. Staff were seen to be attentive, patient and respected people's dignity when assisting them with their meals.

There was evidence the registered manager considered the impact of any restrictions put in place for people that might need to be authorised under the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act (MCA) provides a legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. We discussed the MCA with both the registered manager and staff. The registered manager and staff we spoke with had a good understanding of the requirements of this legislation and were able to describe the processes the service used to make decisions in people's best interests. This included the involvement of people's relatives and family members and the appropriate involvement of health and social care professionals.

People were assessed to see if there were any restrictions in place that might mean an application under DoLs would need to be made. People living at the home had a current DoLS application in place, however not had been

Requires Improvement

Is the service effective?

authorised. We looked at the records of these applications and saw they were all in date and there was a system in place to review at the expiry date or sooner if the people's needs changed and this altered the restrictions in place.

The environment in the service was clean and generally well maintained. Carpets and furniture were in good condition except for some chairs in a lounge which were heavily stained. The registered manager told us they were due to be replaced and were in an area which not generally used by people using the service. Rooms we looked at were personalised with photographs, pictures and ornaments making rooms homely. People living at St Martins did not express their views on the environment but three visitors we spoke with said it was a pleasant and spacious environment for their relatives. One visitor said, "St Martin's was the only home with the care that (my relative) needed. I came to look at it before (my relative) moved in, I was impressed with the amount of staff on duty, it was clean and odour free and they would be able to mix with other people".

A note advising staff of a broken electrical socket cover in a sluice room had been in place since 15 January 2015 but the defect report for maintenance had not been made until 19 February 2015. This was a period of almost a month which showed maintenance reports were not being effectively managed.

Good

Is the service caring?

Our findings

People told us they felt well cared for living at St Martins and staff were kind and compassionate. Visitors told us, “We have noticed the staff with other residents. They speak in a caring and respectful way. We don’t have to worry about (our relatives) care and safety”.

During the morning staff were busy assisting people with care and support. Staff were available in all areas of the service. The service had four lounge areas where members of staff were sitting with people, communicating with them and assisting people with breakfast. All staff were seen to be engaging with people in a warm and caring way. A member of staff told us, “I have been here for a long time. It is challenging, rewarding and hard work but I enjoy it”.

The care we saw being delivered throughout the inspection was appropriate to people’s needs. Staff responded to people in a kind and sensitive way. For example a visitor alerted staff because they were concerned about their relative’s health. A number of nurses checked this person’s temperature, sat with them asked how the person felt and stayed with them. They then moved away and reassured the visitor. The visitor told us this was not unusual and that staff were very responsive if they had concerns.

Staff were using new ‘Person Centred Care Plans’ for people living at St Martins. We looked at one of the completed plans which had been drafted in consultation with the person and a family member. In addition to the necessary health and social care information it contained a life story of the person and included details of their family and previous occupation as well as significant events and achievements. This showed a personal approach which helped staff to know the person they cared for and find out what mattered to that person so they could take account of their choices and preferences.

Visitors told us they could visit at any time and spend time with their family/friends in private. The home had comfortable areas where people could sit if they did not wish to stay in their bedrooms. Visitors were made to feel very welcome and told us they felt they were free to visit at any time.

Since the previous inspection we had received concerns that people’s privacy and dignity had not been protected during a medical emergency. The registered manager told us they had acknowledged the concerns and now had screens which could be used should another incident happen in a lounge or a dining area.

The service had policies in place in relation to privacy and dignity. We spoke with staff to check their understanding of how they treated people with dignity and respect. Staff provided examples of how they worked with people and delivered personal care to ensure their privacy and dignity was upheld. One staff member said, “I treat people as I would expect to be treated or my relatives. It’s important especially as some people do not have control over what they do”. Bedroom, bathroom and toilet doors were always kept closed when people were being supported with personal care. Staff always knocked on bedroom doors and waited for a response before entering.

Good

Is the service responsive?

Our findings

People living at the home did not have easy access to the complaints procedure. 'Have your say' cards' were available to people in the entrance area. There was no other visual information to direct people to the service's complaints procedures. Staff were not clear where they could access this information to support people to raise any concerns they might have. Two complaints had been raised by relatives recently. The registered manager responded to them appropriately with written records supporting the action taken. A relative told us they would go to the registered manager if they were concerned about anything but they were not aware of a formal procedure. However they also told us they did not have any worries about raising a concern or complaint with the service.

During the assessment and development of individual care plans staff supported and encouraged people to express their views and wishes. Because most people were living with dementia, relatives were often consulted and involved in this process. A relative told us, "We made the decision for (my relative) to live at St Martins because we liked the way we were asked to be involved in (my relatives) planning. They took time to get all the information we could help them with and still keep us involved". Other staff members we spoke with told us how they involved relatives wherever possible to gain a broader picture of the person they provide care for. This approach meant staff were able to support people to make choices and decisions and helped them to develop an individualised care plan.

Where possible people had life story books and life histories in their care plans. Staff said this helped them to get to know the likes and dislikes of people. It also gave staff a greater insight into the person's lifestyle, their work and leisure. One staff member said, "It really does help to get to know somebody better because you can focus on something that was important to them and it often creates a little spark of memory. That makes it all worthwhile".

During the day some staff were engaging with small groups in the dining area to take part in crafts. In the afternoon a visiting performer entertained some people. The performer visited the service monthly, sometimes carrying out music and movement exercises and other times singing. They told us there was no plan in advance and that the decision on the activity was made on arrival They said it often depended on the size of the group and how responsive people were. Staff told us activities mainly involved crafts and sing along.

People were supported to maintain relationships with their friends and family members. Throughout the day there were a number of family members who visited their relatives. Family members told us they were always made to feel welcome when they visited the service. Two family members described how they were always offered a drink and also told us they could spend time with their relative in the privacy of their own room if they wished. They told us, "We can visit at any time. Sometimes we help (our relative) with their meal because we want to, not because we have to. We have noticed the staff with other residents, they speak respectfully and in a caring way".

Where people were unable to communicate, staff used other methods to ensure they continued to be involved in their care. One staff member told us, "I supported a resident this morning with what he wanted to wear for the day. (the person) likes to look in their wardrobe to see the style and colours of clothes they have before the make a decision about what to wear". Another staff member explained, "I check people's body language, facial expressions and behaviour changes to identify if, for example, someone was in pain". This showed people were supported to have as much choice and control as possible.

Requires Improvement

Is the service well-led?

Our findings

The previous inspection found some quality assurance tools were not being used effectively and we found there was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

At this inspection we found that where issues had been identified as part of the services quality assurance process there was no evidence of action being taken. We looked at what the service had done to improve its quality auditing procedures. An audit took place in December 2014 looking at staff support, complaints, records and assessing and monitoring the quality of the service. In all areas apart from complaints issues had been identified. They included records not being completed in relation to peoples care and treatment. A sample of food and fluid charts looked at had not been completed in full. Not all records recording people's weights had been completed. Although the issues had been identified during this audit the same issues were found during this inspection. This demonstrated that appropriate actions were not carried out following audits. Following our previous inspection the provider had sent us an action plan which stated it would meet the breach of regulation by October 2014. This had not been done which showed the organisations governance arrangements were not effective in taking action to address breaches in Essential Standards of Quality and Safety as required by the Care Quality Commission.

The registered person was not ensuring quality management systems were operating effectively to act on issues identified during internal audits. This was a breach of Regulation 10(1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had initiated a relatives and friends engagement group. The first meeting informed relatives and friends of the purpose of the group. Its aim was to listen to people and involve them in the quality assurance group aimed to make improvements in the overall quality of the service their relatives and friends were receiving.

The organisation used an independent organisation to carry out an 'annual discovery interview survey'. An independent consultant visited the service making observations over one day. They spoke with four relatives and one person living at the service. The report stated more surveys would be collated over the coming weeks. The survey results were not available. The survey was limited in its results and the number of people whose views were sought. This quality assurance process was limited and there was no evidence of what the outcome was, or what effect it had on the service quality assurance development.

Staff told us they had the opportunity to discuss issues with the registered manager. A meeting was taking place on the day of the inspection. One staff member said, "I think the manager is turning things around for the better". Things have improved and we feel we can raise issues with the manager if we need to. It gives me more confidence". The registered manager had been in post for a short period of time although they had worked as a registered manager with Cornwall Care for a number of years. The registered manager spoke of the importance of ensuring staff were involved and engaged with developments within the service.

Staff told us the registered manager showed good leadership and was approachable and visible around the home when on duty. Staff commented "Things are improving and getting a more static staff team has helped". Some staff said it was frustrating that it was taking time to recruit staff but they wouldn't carry on working in the home if they did not like it. The registered manager told us they were actively recruiting and it was anticipated a full team would be in place in the next few months and therefore there would be less reliance on agency staff.

Staff members we spoke with told us they would be confident to speak with the registered manager if they had any concerns about another staff member. They told us that they had no concerns about the practice or behaviour of any other staff members and that the staff team was developing as a group. However other staff felt there was a division between nurses and care staff. When we spoke with the registered manager about this they provided evidence of staff meetings taking place which showed the importance of working as a team and communicating at all levels.

Requires Improvement

Is the service well-led?

The provider had systems and procedures in place to monitor and assess the quality of their service by engaging with people using the service. These included seeking the views of people through 'resident's meetings', satisfaction surveys and care reviews with people and their family members. We saw 'resident's meetings' were held regularly and any comments, suggestions or requests were acted upon by the registered manager. This meant people who lived at the home were given as much choice and control as possible into how the service was run for them. Visitors we spoke with told us the service was improving and the registered manager took time to explain the changes with them, and asked for their opinions and ideas for the development of the service.

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 9 HSCA (RA) Regulations 2014 Person-centred care We found the registered person was not effectively monitoring people's needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009, which corresponds to Regulation 9 (3)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not ensured safe and effective systems were in place to manage medicines. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person was not ensuring quality management systems were operating effectively to act on issues identified during internal audits. This was a breach of Regulation 10(1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
Warning notice