Ms Gwendoline Swalwell

St Martha's Limited

Inspection report

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Ratings

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

Overall summary

This inspection took place over two days. The first visit on the 8 January 2015 was unannounced which meant the provider and staff did not know we were coming. The second visit on 13 January 2015 was announced.

St Martha's Limited is registered to provide accommodation and personal care for up to 24 older people, including some people who were living with dementia. At the time of our inspections they were 18 people using the service.

St Martha's Limited is located in a large Victorian building that has been converted to its present use. The home is located over two floors and has 24 single bedrooms, three large lounges, two dining rooms and a terrace. There is also a garden that is accessible for people who live at the home.

We last inspected the home in November 2013. At that inspection we found the service was meeting all the essential standards that we inspected.

As the provider is registered as an individual there is no requirement for a registered manager to be in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

People told us they felt safe. We found people's medicines were not managed or administered safely. We also found the provider had not undertaken the necessary recruitment checks to ensure staff were suitable to work with vulnerable people.

We found the registered person did not have an effective system in place to ensure staff received receiving appropriate training and development.

We observed at lunchtime the dining room was nicely set with tablecloths, and a vase with flowers. People told us their meals were good, with adequate portions.

People were supported by sufficient numbers of staff. We saw all staff were very professional and had a patient and caring attitude that treated people as individuals with dignity and respect.

When relatives arrived they were given a friendly greeting. Relatives told us "We can visit anytime and we are made welcome".

Care plans were not reviewed regularly and did not reflect people's changing needs. This meant staff did not have access to up to date information about how people should be supported and cared for.

People and relatives told us they knew who to go to if they had any concerns. One family member said, "I would go to the manager if I needed to".

We observed people taking part in various activities. We saw photographs of outings people had taken part in and of a recent candlelight dinner held for people. One person told us, "We had a lovely night and a good laugh".

We found the provider did not have a formal system in place to monitor the quality and safety of the service provided in carrying on the regulated activity.

We asked the manager about the requirement to make safeguarding notifications to the CQC. The manager told us she was not aware of this requirement. We are dealing with this matter outside of the inspection process.

We cannot confirm that the service gathers information about the quality of their service from a variety of sources. The manager did not have regular procedure in place for gathering the views and comments about the quality of the service provided at the home from people using the service, their relatives, visitors or stakeholders.

Staff did not have structured opportunities to share information and give their views about people's care.

During our inspection we identified six breaches of regulation. You can see what action we told the provider to take at the back 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?

Inadequate

The service was not safe.

We saw that resident's medicines were not stored or administered safely.

We found the provider had not undertaken the necessary recruitment checks to ensure staff were suitable to work with vulnerable people.

We found staff were not aware of safeguarding and whistle-blowing procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

We found the provider did not have an effective system in place to ensure staff received appropriate training and development.

We observed a number of beverage breaks for people throughout the day where staff were ensuring people were taking fluids, with a choice of hot or cold drinks.

Staff we spoke with were not able to tell us what MCA was and when DoLs applied to a person.

Is the service caring?

Good

The service was caring

We observed regular interaction between staff and people who used the service.

We saw staff were professional and had a patient and caring attitude that treated people as individuals with dignity and respect.

Staff we spoke to demonstrated an understanding of how to ensure dignity and respect was maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were no robust systems in place to check that people's needs were being met and that the service was operating safely.

A full time activities co-ordinator provided a full programme of activities for people including activities as games, chair exercises, movies and trips out.

People told us they would be happy to go the manager regarding any complaints they had.

Summary of findings

Is the service well-led?

The service was not always well-led.

The provider did not have a formal system in place to monitor the quality and safety of the service provided in carrying on the regulated activity.

The provider did not ensure statutory notifications had been completed and sent to the Commission in accordance with legal requirements.

People and relatives told us they felt the service was good because staff responded quickly when needed, care was good and meals were ample and of good quality.

Requires Improvement

St Martha's Limited

Detailed findings

Background to this inspection

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

This inspection took place over two days. The first visit was on 8 January 2015 and was unannounced which meant the provider and staff did not know we were coming. Another visit was made on 13 January 2015 which was announced.

On 8 January 2015 the inspection team consisted of three adult social care inspectors 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. On the 13 January 2015 the inspection team consisted of three adult social care inspectors.

Before the inspection, we reviewed the information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We gathered information from Sunderland Council Safeguarding, Sunderland Council Commissioners, Sunderland CCG and Sunderland Healthwatch.

During this inspection we spoke with 14 people who lived at the home, five relatives, five care staff, one senior care assistant, three managers and the registered provider.

We carried out an observation using 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 undertook general observations of how staff interacted with people as they went about their work.

We looked at four people's care plans and 18 resident's medicines records. We examined six staff files including recruitment, supervision and training records. We also looked at other records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

We found that medicines were not managed safely and recorded properly. We examined the Medicine Administration Records (MARs) for 18 people for the period 11 October 2014 to 4 January 2015. We found gaps in records for 14 people where staff had not signed to confirm medicines had been administered or a reason code recorded for non-administration. This meant that we were not able to confirm from the MAR that people had received their prescribed medicines correctly placing them at risk of medicines errors.

We asked for copies of previous completed medicines audits. They provided us with audits for two people dated 2013. When we asked for more recent audits, one staff member told us, "They hadn't been doing them". This meant the provider did not have systems in place to identify and investigate gaps in people's MARs in a timely manner.

We saw that appropriate arrangements for the safe storage of medicines had not been made. Some medicines used at the home needed to be kept chilled. We found that staff hadn't been recording the fridge temperature since October 2014. Therefore the provider was unable to confirm that these medicines were stored appropriately. It is important that all medicines are stored at the correct temperatures to ensure they are safe to be given to people. We saw that some medicines were stored in a locked medicines trolley which was located in a communal area of the home. However, the trolley did not have any means to be secured to the wall for additional security. As required in the medication policy.

Some people had been prescribed 'when required' medicines. Staff told us that there were no 'when required' protocols in place. These are important so that staff know when and how to administer these medicines to people safely. We noted two people were self-medicating with their inhalers. However, there were no assessments in place considering the risk of potential non-compliance with taking their inhalers when they needed them. This meant that we were not able to see that staff had an understanding of medicines and a person's changing needs.This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found the provider did not carry out appropriate checks to ensure staff were suitable to work with vulnerable adults. We looked at the Recruitment and Selection Policy and Procedure dated 13 October 2010. This detailed the processes to be taken before new staff started their employment. The policy stated, 'All candidates will be required to undergo Criminal Records Bureau and ISA checks' and 'A minimum of two referees will be contacted.'

We examined six staff records and found four did not hold or record that reference checks had been conducted. We asked the manager whether a process was in place to monitor the receipt of references. They told us that no audit was in place at present. However, a human resources (HR) manager had recently been employed and was in the process of evaluating the recruitment process.

We found that one staff member's recruitment record included a Disclosure and Barring Service (DBS) check for a previous employer. This was dated twelve months prior to starting with the provider. We noted no further DBS checks had been conducted for the staff member's current employment. We saw within another staff member's records the DBS certificate was dated after the start date of their employment. DBS checks help employers make safer recruitment decisions and help to prevent unsuitable people from working with vulnerable adults.

We found that recruitment checks were not always completed before staff started working with vulnerable people. The registered provider advised us that she had previously allowed a new member of staff to work before a DBS enhanced disclosure notification had been returned. She accepted that she had not followed safe recruitment practices but was under pressure to find someone as they were short of staff that evening. She stated that she had since dismissed the member of staff. This meant the provider had not undertaken the necessary checks to ensure staff were suitable to work with vulnerable people. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We viewed the provider's Safeguarding Policy. However, we found this contained out of date information. For example, the safeguarding manager information was out of date. The manager told us that she intended to review all policies. Following our inspection the manager provided us with an amended version of the policy.

Inadequate

Is the service safe?

The provider did not have adequate systems in place to record and investigate safeguarding concerns. We asked the manager how safeguarding concerns would be dealt with. They told us they would discuss the concern with Local Authority Safeguarding Team. However there was no record or log of actions taken. We asked the manager if an audit of safeguarding allegations was conducted. The manager told us there was no audit in place. We asked the manager about the requirement to make safeguarding notifications to the CQC. The manager told us she was not aware of this requirement. We are dealing with this matter outside of the inspection process.

We viewed the computerised training records for all staff. These showed that no new starters had received safeguarding training. The manager confirmed the training records were up to date. A staff member told us, They hadn't been made aware of the whistle blowing procedure but did not have any concerns. One staff member told us, They had not received any training in safeguarding whilst at St Martha's and were unsure where the policies around safeguarding and whistleblowing in St Martha's were held and also where the local authority safeguarding contact details were kept. This meant that new staff did not receive training and guidance to enable them to raise concerns to the appropriate person.This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We examined the 'Accident and Incident Folder'. We saw records were completed and logged. Records included a description of the incident and the action taken. We asked the manager if an analysis was carried out to identify any trends or contributory factors which may require investigation. They advised no such audit was in place. This meant that the home was failing to conduct an analysis of incidents that had resulted in harm to service users, in order to improve the care being provided to help keep people safe.

We found there were checks in place to ensure the safety and security of the home and equipment. We spoke to the maintenance person who had a good understanding of their area of responsibility. We saw all records were completed and up to date, including regular assessments for fire alarms, fire equipment, lifts, hoists, water temperatures and gas safety.

We examined the emergency evacuation procedure. We saw it contained each person's details, room location and the support they required from staff in an emergency. However, we found these records were not complete or up to date. For example, we saw that seven people did not have their details recorded. Another person's mobility had changed as they now required support with a wheelchair. We saw their emergency evacuation plan did not reflect this need. This meant the provider did not have suitable plans to keep people safe in an emergency.

We found there was enough staff to meet people's needs. We asked the manager how staffing levels were assessed. They advised that the levels were determined by people's needs. We reviewed that rotas over a three month period and found that the expected staffing levels had been deployed. We observed plenty of staff on duty and they were very visible and call bells were answered quickly. One person said, "They respond quickly to my call bell."

We reviewed four people's care records. We found that personal risk assessments for key elements of care, such as moving & handling and behaviour that challenges were out of date. For example, for one person their moving and handling assessment had not been updated since February 2014. This meant that risk assessments were not up to date and therefore staff did not have access to current information about how to keep people safe

Requires Improvement

Is the service effective?

Our findings

We found that training and development was not up to date. We looked at staff training records for all staff and viewed an electronic training matrix. This showed the last training for staff had taken place in September 2013. Fire safety was the only recorded training for new starters, which was held in November 2014. We asked the manager what training was available for staff. They advised that they were aware of issues in training and had recently employed a new HR manager to deal with this matter.

We spoke with staff regarding training. One care worker told us, They had not undertaken any training since starting at St Martha's twelve months ago. Another care worker advised, "I haven't done any training for a while but I am always open to it." Another care worker told us that they had not received any moving and handling training. However, we observed the same care worker supporting a person from an armchair. We brought this to the attention of the manager who advised us they would ensure the care worker received the appropriate training. This meant that we were not able to confirm that staff had the appropriate skills and knowledge to ensure people's needs were met.

Staff were not receiving regular supervision and appraisal. Supervision and appraisal is important so staff have an opportunity to discuss the support, training and development they need to fulfil their caring role. We examined six staff records and saw four recorded supervisions had taken place between 2012 and 2013. None of the six staff records held details of any appraisals having been conducted. One staff member told us, They had not had any formal one to one with their manager since they had started at St Martha's however they did feel the manager was approachable. The manager told us the new HR manager was in the process of evaluating all areas of recruitment including training and development. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke with people about meal times and choices available to them. People told us the food was good, with adequate portions. One person said, "The activity organiser asks us each morning what we would like for lunch and tea. Breakfast is more or less when you want it".

We observed over the lunchtime period. We saw tables were set including tablecloths and a vase with flowers. Staff had a list of what people had ordered but people were still told they could have something else if they wanted. A couple of people asked staff for a little assistance with cutting up their food and this was given sensitively. Staff we spoke with had an understanding of the nutritional needs of people living in the home. Throughout lunch staff kept checking if everyone was alright and asking if they needed anything such as more juice.

We observed a number of the interactions between people and staff. We saw staff checked with people that they had the people's permission to do something. Such as, "Are you ready for your medicine", or "Do you need a hand with cutting up that meal".

We spoke with the cook and they stated they were happy to prepare an alternative to the meals on offer if people requested. We observed a number of beverage breaks for people throughout the day where staff were ensuring people were taking fluids, with a choice of hot or cold drinks.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests.' It also ensures unlawful restrictions are not placed on people in care homes and hospitals.

The manager advised that no one had been assessed as lacking capacity and that no DoLS applications had been to the local authority. When speaking with staff, we identified a number of people who lived at the home who might require an assessment, to ascertain if they fell within the threshold for a DoLS application. The manager told us management had received training in MCA and DoLS and were able to articulate the principles behind them. A staff member we spoke with was not able to tell us what MCA was and when DoLs applied to a person. There was no record of staff receiving training on this subject.

We examined four care plans and noted one held a blank MCA assessment form. We did not see evidence of MCA assessments and 'best interests' decisions being carried out for people who lacked capacity to make decisions for themselves. This meant people's rights against inappropriate restriction of liberty were not protected

Requires Improvement

Is the service effective?

because appropriate measures were not in place to make the required assessments and applications, in line with MCA and DoLS legislation. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff gave us examples of the various health professionals involved in people's care, including GPs, community nurses, dieticians and dentists. A staff member told us appointments to external health care professionals were recorded in the daily book.

We observed staff reacting quickly when a person become unwell. A care worker asked the person if they needed a drink, to go to their room or did they need a doctor. Relatives also confirmed they were contacted quickly by staff if health or other problems arise.

The laundry room was clean and tidy and we noted people had individual baskets for their own clothing. The manager advised that items can be mixed but once this has come to light they resolve the issue straight away. We noted the majority of the bedding laundry is completed by external provider with in house service assisting when required.

We saw no information on display for people or visitors about who staff were and their roles, safeguarding or whistle-blowing. The registered manager told us they preferred for the home to maintain its homely atmosphere and all information is available if asked for.

Good

Is the service caring?

Our findings

We observed people received regular interaction from staff. People and relatives told us they were very happy with the care. One relative told us, "We did look at a few homes which we were not happy with. A friend suggested this one and it is really good". They added, "We agreed the care package prior to admission and I am happy with the care given." One person told us they had no complaints about living there. Comments included, "The girls will do anything for you. Nothing is too much bother"; "When I came in they made me feel welcome."

Staff treated people with dignity and respect. For example, we saw staff knocked and waited for a response before entering people's rooms. We also saw care workers regularly checked on people who were in their own rooms. They also spent time in the sitting room to making people had the assistance they needed and talking with people.

We saw staff were professional and were patient and caring towards people. One person told us, "Everything's good, they treat me well". Another resident told us, "Staff are very nice and respectful, and my dignity and privacy is respected. They knock on doors and ask if I need a bath or a change of clothing, always with a smile on their faces".

Staff we spoke with had an understanding of how to ensure dignity and respect was maintained. One staff member told us they always ask before giving care, making sure the resident was covered when changing and delivering personal care and constantly checking they were ok.

A relative told us they were very happy with the staff at the home. They told us they had been involved with the hospital, a social worker and St Martha's staff regarding their relative's assessment to ensure St Martha's was able to support their relative with their care requirements. One relative told us, "Staff are always friendly". Whilst another relative said, "They keep us updated on if the doctor has been out".

We observed staff responded quickly when call bells were activated for those people who remained in their rooms. We saw positive interactions with people and staff as tea and biscuits were being served, with staff giving people the option of a hot or cold drink. We observed staff calling people by name and waiting for their response.

The manager told us about the community links St Martha's had developed over the years. For example, a local 60's club, a recent programme with the Prince's Trust and links to St Mary's Church. A church communal service was held during the morning of our inspection. This was well attended; ensuring those who wished to receive Holy Communion had the opportunity.

We spoke with the visiting hairdresser. They told us they visited the home three days a week. Apart from doing people's hair they spent time asking people if they would like their nails done which many did. A hair salon was available on the top floor and the hairdresser also attended to those people who preferred to remain in their rooms. The manager also advised us a chiropodist visits the home on a regular basis.

Requires Improvement

Is the service responsive?

Our findings

We found care plan reviews were not up to date. For example, we saw that two care plans hadn't been reviewed since they were initially developed in February 2014. Another care plan had not been reviewed since August 2013. We looked at the care plan policy it stated reviews would be carried out "at least monthly". This meant staff did not have access to up to date information about how people should be supported and cared for.

Care plans did not reflect a person's current needs. For one person a mobility assessment had been conducted on 1 March 2014. The assessment did not reference that the person now used a wheelchair. We observed the person was using a wheelchair during our inspection. However, their care plan did not reflect this need.

People and relatives told us they could not recall having a formal review of their care. One relative said, "Things are taken care of as necessary so I have no concerns." We spoke with the manager about this. They told us they were aware of the need to update the care plans and was planning review all care plans. This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at four people's care plans and saw these contained some personalised information about their preferences. For example, one person enjoyed a small glass of white wine/sherry and preferred a small plate at mealtimes. Care plans covered a range of needs such as personal hygiene, washing and bathing; dressing; continence; nutrition; mobility; communication; medication; oral hygiene; end of life and activities.

We asked people what they would do if they had a concern or complaint about the service they received. None of the people we spoke to reported they have ever had cause to make a complaint. One person said, "I have not found anything to complain about". People and relatives told us they knew who to go to if they had any concerns. One family member said, "I would go to the manager if I needed to".

We did not see a complaints policy on display however the manager told us when residents first arrive at St Martha's they receive a residents handbook which includes information in regard to complaints, comments and compliments, advocacy, safeguarding and staff details.

We viewed the complaints, comments and compliments policy it was last reviewed in October 2010. The manager told us they were in the process of reviewing all policies and procedures. They also advised there had been no formal complaints received.

The manager told us the home employed a full time activities co-ordinator. They said the activities co-ordinator had completed training in dementia and they delivered a full programme of activities. This included activities such as games, chair exercises, movies and trips out. One person told us, "There are plenty of activities and they are enjoyable."

We observed people enjoying singing tunes in a reminiscence activity called 'A trip down memory lane', and taking part in a musical quiz. We were shown photographs of outings and a recent candlelight dinner held for people living at the home. One person told us, "We had a lovely night and a good laugh."

Staff told us people have one to one time with staff including having chats, having their nails painted and playing dominoes. They said, "They [staff] try and do it a couple of times a week." One person told us, "If I stay in my room staff will ask if I would like my friend brought to the room so we can chat and that is great."

Requires Improvement

Is the service well-led?

Our findings

We examined all the policies and procedures relating to the running of the home. We found that most of these had not been reviewed and maintained to ensure that staff had access to up to date information and guidance. For example, the policies we viewed were dated had been last reviewed between 2009 to 2012. We also found the Residents' Handbook contained information about complaints and safeguarding but this information was out of date, specifically the staff list and local authority contact details.

We found evidence that accidents and incidents were being recorded. We asked the manager if an analysis of accidents to establish any trends or contributory factors had been conducted. The manager advised that no analysis had taken place. This meant the home had failed to review accidents and incidents resulting in harm to people to minimise the risk of them happening again and to help keep people safe.

During our inspection we identified areas of concern. We found that the provider did not have effective systems in place to identify these issues and other areas of concern. We asked the manager for evidence of specific audits or quality checks including checks of staff training records, staff recruitment records, complaints and whistleblowing. We were not provided with any evidence that these were regularly undertaken. We asked the manager to tell us about the audit systems currently in place. They said no audits were carried out and there were no formal quality assurance processes in place. This meant that the provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure that people received appropriate care and support. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff did not have structured opportunities to share information and give their views about people's care. The provider did not hold regular team meetings. We asked the manager for details of any staff meetings that had taken place. They said they could not recall the date of the last meeting held. Staff we spoke to told us, They had not attended any team meetings and were unsure if there had been any held..

We asked the manager for the minutes of any meetings involving people who used the service. The manager told us one meeting had taken place prior to Christmas. Two people we spoke with said they had attended. Of the six people we spoke to no one could recall completing a questionnaire about the service. This meant we could not confirm the provider regularly sought the views of service users or persons acting on their behalf, or the staff to enable the provider to come to an informed view in relation to the standard of care and treatment provided to the service users.

We asked to see the minutes from staff meetings that had taken place. The manager was unable to provide copies and was unable to recall the date the last meeting was held. One staff member told us, She had not attended any team meetings and was unsure if there had been any held. Another told us, They could not recall the last time a team meeting had been held.

There was a nice atmosphere in the home and we saw that people looked happy, calm and content. Staff we spoke with said they were happy in their work. They also said they felt supported in their roles by management. People and relatives told us they felt the service was good because care workers responded quickly when needed, care was good and the food ample and of good quality.

Relatives told us the home was welcoming. For example, they said when they arrived they were given a friendly greeting and asked if they would like a hot drink as it was cold. Relatives told us, "We can visit anytime and we are made welcome".

We asked the manager for confirmation that statutory notifications been completed and then sent to the Commission in accordance with regulatory requirements. The manager stated they were not aware of the requirement to inform the Commission. They confirmed there was no monitoring system in place to ensure that statutory notifications were being completed and submitted when required. We are dealing with this matter separately from the inspection process.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The provider did not have suitable arrangements in place to ensure staff were appropriately supported to enable them to deliver care and treatment to people because they were not receiving necessary training.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person did not have suitable arrangements in place to identify, prevent and investigate any safeguarding allegations.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **People who used the service were not always protected against the risks of inappropriate care because accurate records in relation to their care were not in place.**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not fully protected against the risks associated with medicines because the provider did not manage medicines appropriately.

The enforcement action we took:
A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The provider did not have an effective system in place to regularly asses and monitor the quality of the service provided.

The enforcement action we took:
A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Appropriate recruitment checks were not always undertaken before staff started to work at the service to ensure staff were suitable to work with vulnerable people.

The enforcement action we took:
A warning notice was issued.