Bupa Care Homes (CFHCare) Limited

Seabrooke Manor Residential and Nursing Home

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

Overall summary

This inspection took place on 30 January 2015 and was unannounced. A second visit took place on 9 March 2015. At our last inspection in September 2014, the service had not met legal requirements relating to consent to care and treatment and care and welfare of people using this service. At this inspection there was no improvement and they were still not meeting these requirements.

Seabrooke Manor is a 120 bed care home providing residential and nursing care. The service is divided into four units. Norman House and Belgae House provide nursing and residential care. Saxon House provides residential dementia care and Roman House provides nursing dementia care. On the day of our visit there were 113 people living at Seabrooke Manor.

Summary of findings

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

During this inspection we found the provider was not meeting some of the legal requirements relating to consent to care and treatment, care and welfare, record keeping, information and involvement, cleanliness and infection control. You can see what action we told the provider to take at the back of the full version of this report.

People were not always cared for in a clean and hygienic environment. People were at risk of contracting infections as appropriate guidance was not always followed. Infection control guidelines such as handwashing, single use of hoist slings and syringes were not always adhered to. Some staff had visibly dirty uniforms.

Risk assessments were not always completed and did not always explain how the identified risk could be minimised in order to protect people using the service. Enteral nutrition was not always managed appropriately in accordance with enteral nutrition best practice guidance. This could put people at risk of aspiration and infections.

People were not always treated with dignity and respect. We saw people with their undergarments exposed. Although care was assessed, care plans were not always individualised or reviewed to reflect the current needs of people using the service.

We saw inconsistencies in leadership styles. Some units were very task oriented whereas other units were more person centred. However, on the second visit when all unit leaders were present all units were better organised.

Staff had attended appropriate training. Regular supervision including group supervision and annual appraisals were completed in order to ensure that staff were supported to provide care to people using the service.

There were safer recruitment practices in place which included appropriate checks to ensure staff were suitable to work with vulnerable adults. Medicines were handled and administered safely.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). There had been several applications for Deprivation of Liberty Safeguards (DoLS) for people using the service. The registered manager and staff had recently attended training, and showed an awareness of how to lawfully deprive people of their liberty where this was in the person's best interests.

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 always safe. People were not cared for in a clean and hygienic environment. Infection control policies were not always followed putting people at risk of acquiring infections.

People's risk assessments were not always completed and did not always explain how the identified risk could be minimised in order to protect people using the service.

Medicines were handled and administered safely.

There were safer recruitment practices in place which included appropriate checks to ensure staff were suitable to work with vulnerable adults. Staffing levels were reviewed regularly.

Is the service effective?

Requires Improvement

The service was not always effective. Enteral nutrition was not always managed appropriately in accordance with enteral nutrition best practice guidance.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). There had been several applications for Deprivation of Liberty Safeguards (DoLS) for people using the service at the time of our inspection. The registered manager and staff had recently attended training, and showed an awareness of how to lawfully deprive people of their liberty where this was in the people's best interests. However, care plans we reviewed did not always reflect this.

Staff had attended appropriate training. Regular supervision including group supervision and annual appraisals were completed in order to ensure that staff were supported to deliver safe care to people using the service.

Is the service caring?

Requires Improvement

The service was not always caring. People were not always treated with dignity and respect. We saw people with their undergarments exposed, another with dirty clothes and another with matted hair. We observed that staff were task oriented on one unit and spent an hour sitting in the dining room updating care records without any interaction with people who used the service.

Although we received some positive feedback from relatives of people on end of life care, the majority of our feedback and observations in two of the four units were negative.

Staff demonstrated knowledge on how they promoted equality and diversity by respecting people's religious, cultural and educational backgrounds.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not responsive to the need of people using the service. Although care was assessed, care plans were not always individualised or reviewed to reflect the current needs of people using the service.

There were systems in place in order to acknowledge, respond to, resolve and learn from complaints.

People's relatives could visit at any time. Activities were arranged where possible to suit people's preferences.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led. We saw inconsistencies in leadership styles. Two units were very task oriented whereas other units were more person centred.

There were clear values and a vision displayed within the service. However care staff were not always aware of how these values and vision related to their daily work.

We saw several audits in place to monitor the quality of care delivered. However, these had failed to address shortfalls we found relating to cleanliness and record keeping. People's views were sought for and action was taken to address any concerns expressed during annual surveys and meetings where people using the service were involved in.

Seabrooke Manor Residential and Nursing Home

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 30 January 2015 and was unannounced. The inspection team comprised of an inspector and a specialist advisor in nursing. One inspector returned on 9 March 2015.

Prior to the inspection we looked at the information we held about the service including notifications they had sent us and information from the local authority and the local Healthwatch.

During the visit, we spoke with 13 people using the service, five relatives, three nurses, four care staff, unit lead, clinical lead, an activities coordinator, two staff trainers, and the registered manager. We observed how staff interacted with people who used the service.

We looked at eight records of people who used the service, 18 medicine administration records and five staff records. We also looked at records related to the management of the service. This included a range of audits, the complaints log, minutes for various meetings, safeguarding records, the health and safety folder, and policies and procedures for the service.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe. One person said, "Staff are quite good and look after us well here." Another said, "I have no concerns about my care or treatment here. I don't think anyone would deliberately harm me."

However, we found that people were not always cared for in a clean and hygienic environment. Although we saw cleaning schedules in place and a cleaner allocated to each unit, there were shortfalls as four communal toilets were dirty and the stairwells to each unit had grey dust present on artificial flowers and picture frames. One ensuite bathroom was dirty with excrement clinging to the side of the toilet bowl. Another toilet had used toilet paper left on the floor. There was a smell of urine on one of the nursing units. The laminate flooring on the same unit was sticky underfoot. Whilst the beds we observed being made were given clean bed linen, we noticed that this was sometimes stained and discoloured.

During our inspection on 30 January 2015 we also witnessed three chairs and one sofa which were stained. When we asked if these were to be replaced, the unit manager suggested that this was the case but could not say when this would be. Where there were carpets in the remaining units these were stained with unknown substances. The carpet in the lift in one unit was covered in debris and did not appear to have been cleaned. We asked the registered manager and clinical lead about the stains and they told us there was a renovation plan and that they could not get rid of the limescale in the toilets.

People were at risk of infection because appropriate guidance was not always followed. Whilst there was a hoist, we noted that the same sling was being used for several people. We were told by a unit manager that the slings were "washed in the machine at the end of the day". Whilst this was positive, there was no evidence to suggest that the sling was cleaned in between use and staff did not have an awareness of the need to use one sling per person. This posed both an infection control and safety risk as slings also came in several sizes which could put people at danger of falls if the wrong sling size was used.

Enteral care was not always delivered according to guidance or in a manner that protected people who used the service. There was no evidence of feeding tubes being labelled, or any documentation in the care plan for any person on NG feed to suggest when the giving set had last been changed. We observed on 30 January that the paper towel used to drain the reused syringes for people on enteral feed, was dirty and had stains. This constituted poor practice and had the potential to cause an infection. We also observed that the syringes which had been used and washed still had residual water in situ which could breed bacteria and cause an infection risk. However, this was not the case on 9 March 2015 as all syringes were labelled and kept in wrappers and the unit leader informed us they did not label giving sets as they changed them daily.

We witnessed that there was exudate underneath the dressing of a person at the PEG site. However, the care plan did not give any detailed instructions as to how the PEG site should be cleaned and how often the dressing should be changed. This lack of attention to detail placed people at risk of developing further infections.

We found no hand towels to dry our hands after handwashing in the staff toilet. We observed three members of staff whose uniforms were dirty on 30 January 2015. Two members of staff were wearing trainers which was a clear breach of the service uniform policy which stated that trainers were not allowed and staff were to wear clean uniforms each day in order to protect people from cross infection.

Although risks to people were documented, the interventions to mitigate the risks were not always clear. One risk assessment for a person with swallowing difficulties (dysphagia) did indicate that a swallowing assessment had been carried out. However, the same care plan did not give staff clear direction on what to look out for while assisting people with swallowing difficulties. A care plan for another person with dysphagia who was receiving nutritional support via a nasogastric tube stated that they may also be offered pureed food. However, within the intervention, it was stated that "if there are any problems with the pureed diet, to inform the dietician or the Speech and Language (SALT) team." It was not documented anywhere in the care plan immediate action to be taken if choking occurred. This left people at risk from aspiration of food and fluid into their lungs.

We also observed three wheelchairs that had been condemned as not fit for purpose were being used to transport rubbish and waste. This was an inappropriate use of such equipment. We also observed two wheelchairs

Inadequate

Is the service safe?

which did not have any footplates, however it was not clear if these were being used for to transfer people as they were in one of the bathrooms and we did not witness them in use.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 , which corresponds to regulation 12 (1)(e) (2) (a)(b)(c) (e) (h)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Medicines were stored, handled and disposed of appropriately and administered by staff who had been assessed as competent. Controlled drugs were checked daily and 10 medicine administration records (MARS) were audited daily on each unit to ensure that any discrepancies were rectified. We looked at 18 MARS and found no discrepancies.

Staff were aware of the different types of abuse and explained to us how and where they would report any witnessed or allegations of abuse. They knew where to locate the safeguarding policy and told us that they were able to express any concerns they had relating to the care delivered. They were aware of the whistle blowing procedure and told us they would not hesitate to report any poor practices that may put people at risk to their unit manager or the registered manager.

There were procedures in place to monitor and manage incidents and accidents. Staff told us and showed us how they used body maps to records any bruises and showed us incident forms they used to capture data such as falls, pressure sores and any medicine errors. Staff told us that unit leads discusses these with staff at meetings and any learning or changes to the management of people were shared during every handover.

There were procedures in place to handle foreseeable emergencies. Staff had attended basic life support training and could tell us the procedure to follow in both a medical emergency and in the event of a fire. Regular fire drills were completed. However, we noted that one evacuation bag was blocked in a stairwell by discarded furniture and was a fire hazard. We were told that all the obstructions would be removed before the end of our visit and saw that the process had started before we left.

Staffing levels were reviewed and determined by the dependency of the people using the service. We reviewed rotas from November and December 2014 and found that where sickness or shortages occurred temporary staff were used to cover the shifts.

We looked at five staff files and found that robust recruitment procedures were in place. These included appropriate checks to ensure that staff were suitable to work with vulnerable adults. Two references, proof of identity, qualifications and occupational health clearance was also kept on file. Staff were made aware of recruitment policies including sickness and absence and annual leave. We spoke to the registered manager about the disciplinary process and they told us that they had support from human resources to enable them to carry out disciplinary procedures in order to protect people from poor care delivery practices.

Requires Improvement

Is the service effective?

Our findings

At our inspection in September 2014, we identified shortfalls in how people's capacity to understand and consent to decisions about their care was assessed by the service staff. We asked the provider to send us an action plan outlining how they would make improvements. When we inspected the service on 30 January 2015 and 9 March 2015 we found that some improvements had been made, but we still had some concerns. Staff were aware of the people who were subject to a Deprivation of Liberty Safeguard (DoLs) and we saw that appropriate authorisations had been completed. However, one of the care plans reviewed was for a person who was at risk of wandering out of the service. Although staff had recognised this was an issue and had raised a request for a DoLS the concerns with regards to this person's potential to wander out had not been documented anywhere in their care plan. This could put the person at risk if the staff caring for them were not aware of their potential to wander out of the building.

Seven of the eight care plans we reviewed had a partially completed Mental Capacity Act form enclosed. One person's care plan had a blank Mental Capacity Act form. It was of concern to note that within the same care plan staff had documented that the person "had capacity" to make decisions without evidencing how the person was assessed for capacity. Two of the forms reviewed had a "blank box" where the form asked if the person had been involved in the decision making process to determine their best interests. It was also of concern to note that one person's care plan stated that they "… participated but they didn't understand what was happening."

In another care plan we reviewed, a relative had signed a letter stating that they did not wish their mother to have any further treatment which implied that they had a legal right to make decisions on their mother's behalf. However, this was not stated in the letter or documented anywhere in the care plan. Furthermore a nurse we spoke with could not explain power of attorney (POA) or deputyship or understand the importance of knowing who held power of attorney for people with regards to their finances or health and welfare. The POA section of the Mental Capacity Act Assessment forms in all eight care plans that we reviewed had all been marked as "not applicable". This showed staff had limited understanding with regards to the Mental Capacity Act, despite all staff we spoke with having received some training on this subject.

This had serious implications on care as relatives may have been asked to make decisions on people's behalf when they did not have the legal right to. This left people at risk of their best interests not being protected.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit staff told us and we saw a poster on the wall in all the units which suggested that snacks and drinks were available day and night. We saw that people were served afternoon tea consisting of tea and cake. We observed lunchtime and found the meals provided were nutritionally balanced. Staff wore protective aprons whilst serving meals. People were given freshly laundered napkins and sat at clean tables which had table cloths. We observed people being given a choice as to what they wanted to eat or drink. A relative we spoke to said "the food here is good but it isn't very hot". Two people also said the food was not always hot.

Staff told us they attended annual training for infection control and first aid. They had also received training on Dignity and nutrition and dementia care we saw evidence of this in training records. We also spoke with trainers who were on site on the day of our visit who showed us the training matrix and the training program for 2015.

We witnessed that one of the units had murals on the walls which were painted brightly in order to engage with people with dementia. Staff told us that the several chairs we saw in the corridors were rest stations for people to use as they moved around within the service.

Regular supervision including group supervision and annual appraisals were completed in order to ensure that staff were supported. We saw evidence that group and individual supervision took place where staff were able to reflect on practice and learn from current incidents. Staff told us they had been appraised in the last year and we saw evidence of this in the files we reviewed.

Requires Improvement

Is the service caring?

Our findings

Although we received some positive feedback from people's relatives on end of life care, the majority of our feedback and observations in two of the four units were negative on 30 January 2015. People were not always treated with consideration and respect. We observed that people were spoken with and treated with respect on two out of the four units. Doors were closed while people were assisted with personal hygiene needs. We could hear staff offer choice and laughing with people whilst delivering care. Staff told us they used towels to protect people from unnecessary exposure and promote dignity. We also witnessed a person having their hair washed and blow dried. However, we also saw several incidents on the remaining units where people's dignity was not respected. There was an incident during serving breakfast, whereby a member of staff was overheard shouting at a person, "you will have to wait like everyone else!" Similarly during meal times we saw two other people who were not supported to eat their meals appropriately.

During the 30 January visit we saw two people seated in chairs with their undergarments exposed. Another person was wearing stained, dirty clothing which had multiple holes and their hair was greasy and matted. Furthermore, another person sat in their room with a full commode and there was evidence that they had eaten breakfast with the full commode by their side.The care plan stated that this person did not want the commode removed, however the commode could have been emptied. We also noted that although there were locks on all toilet doors, the locks on three toilet doors did not have any red coloured bar within the lock to indicate when someone was using the facility like the rest.

During the afternoon of 30 January 2015, we observed on one unit, three members of staff sitting writing notes in the main lounge. These staff members were focussed on their note writing and there was no interaction between them or the people seated in the lounge. This did not show consideration or respect for people were in the lounge who were left seated on chairs for an hour with no staff interaction.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2010 which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's diversity was respected. Staff told us how they accommodated people's preferences including their religious or cultural preferences during personal care and meal times. They gave examples of how people's wishes to be assisted with personal hygiene needs by same gender care staff were honoured. One staff member said they did their "best for people". Another staff member said they treated people like their own "brothers and sisters".

People were allowed to be independent. We observed three people walking around one of the units together, enjoying an animated conversation. We observed that people who liked to smoke were allowed to do this outside, although they were not supervised. We saw staff encourage people to mobilise within the service.

People told us that they had been involved in decorating their room, in choosing their clothes and when choosing what to eat. One person said, "I got to bring my own furniture when I moved in." Another showed us pictures of their family displayed within their room whilst another said, "those paintings have been our family for generations. They remind me of precious times shared with family and friends".

Requires Improvement

Is the service responsive?

Our findings

At our inspection in September 2014, we identified shortfalls in the assessments and review of care plans. We asked the provider to send us an action plan outlining how they would make improvements. When we inspected the service on 30 January 2015, we found that some improvements had been made, but there were still some concerns relating to the assessment, planning and reviewing of care given.

We observed that eight care plans had personal history and individual preferences for patient care documented. Two out of the eight care plans we reviewed were completed correctly with individual interventions and good outcomes for the people using the service. However, the remaining six care plans and records were not individualised or updated to reflect people's needs. One care plan stated that a person was at risk of developing pressure ulcers and was put on a turning chart. We observed that the last entry for the turning chart was dated in December 2014. The same person was also documented as being at "a high risk of falls" with a stated intervention of "2 hourly checks". Whilst this was positive, we could not see any evidence to suggest in documentation that these checks had been carried out, which was cause for concern.

Another person had recently had been given Do Not Attempt Resuscitation (DNAR) status but this was not reflected anywhere in their care plan. A fifth care plan for a person who had suffered skin tears, one of which had become infected on the 19th January 2015, stated "antibiotics given" however there was not any clear intervention written as to how the wound was being cleaned or cared for.

A care plan for a person who had difficulty with their mobility documented that they "cannot weight bear for more than a few seconds". However, the evaluation stated, "does not like to use a Zimmer frame". This showed there was a lack of understanding of the care planning process as the evaluation was not holistic or person centred and made the care planning process more of a "tick box" exercise rather than a reflection of the person's care needs.

We also reviewed a care plan for a person who was also deemed to be "at risk of scalding herself without supervision". The following intervention stated "offer a milky drink at night before bedtime" but nowhere did this state that this beverage should be given with a care worker present. We reviewed a care plan for another person with poor mobility. However, whilst the interventions were clearly stated, the evaluation of this care plan was very poor whereby it was written "all nurses had received manual handling training". This did not state how this can improve the person's care and there was no link between theory and practice, thus suggesting that care planning was not holistic or person centred.

We reviewed a care plan for a person who had a problem of maintaining skin integrity. One of the interventions stated "likes to sleep in a chair". This intervention did not say how skin integrity is compromised or give any clear direction as to how to prevent the formation of pressure ulcers. Therefore the person had an increased risk of skin breakdown. We reviewed another care plan for a person identified as having a problem managing pain. The intervention stated that paracetamol was being given to help manage their pain. However, an evaluation entry dated December 2014 stated that the person was managing to take the paracetamol tablets. However, the next entry dated nine days later said that the person was not managing to take the tablets. There were no further details to clarify exactly what was meant by this statement. Moreover, the care plan was not altered to suggest new ways in which to manage the person's pain. This record did not show us what was done to manage their pain. It would have been useful to explore if the person could receive the paracetamol in a liquid form, or be offered an alternative medicine.

This lack of attention to individual detail seen in the nursing interventions, and the poor evaluations of nursing care, suggested that the care planning process was not always followed properly in order to ensure person centred care. One nurse we spoke with informed us that "I have asked for care planning training". When we spoke to the manager about the poor care planning we observed, they suggested that there was to be a new care planning process in place with new, shorter forms. Training was to commence shortly.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they could express their concerns to the manager or any member of staff. The complaints system

Requires Improvement

Is the service responsive?

was displayed within the service and also highlighted in the service user's guide. There were systems in place to acknowledge, respond to, resolve and learn from complaints. We reviewed the complaints that the service had received and found that they were acknowledged and responded to in line with the provider's policy. Staff told us they would escalate any complaints to the unit lead (manager of the unit). They gave an example of how staff were now vigilant about labelling clothes as a result of people's clothes remaining unclaimed due to unlabelled clothes.

People told us they could receive visitors at any time. One person said, "My daughter comes as often as she can." Another person said, "My family can come at any time they choose."

Activities were arranged where possible to suit people's preferences. However, on the day of our visit there was one activity coordinator trying to cover four separate units. We saw one-to-one discussions, games and nail painting sessions. People told us they could participate in activities when they chose. We saw a cinema with VHS tapes that was used regularly. On one of the dementia units there were colourful doors and renaissance wall murals around the corridors in order to try to stimulate people living with dementia.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place who was supported by a deputy manager, an allocated home educator/trainer and a regional manager who supported the manager . The registered manager had informed the Care Quality Commission (CQC) of important events that happen in the service in a timely way. This meant we could check that appropriate action had been taken. There were monitoring systems in place which included audits on quality issues such as, records, medicines, infection control and health and safety.

People told us that they could approach the registered manager at any time to express their concerns. We observed on two of the units positive interactions between staff and people who used the service. People told us they could talk to staff and the manager without hesitation. One person said, "I can talk to staff about anything. The manager comes around often and asks if everything is ok." They thought they was an open door policy and that issues or concerns raised could be discussed without fear. Each of the four units was led by a unit manager. Staff were clear on the reporting and escalation structure for each unit. We spoke to a care assistant and a nurse both told us that "we can approach the manager at any time, she is really good." Another care staff care assistant stated that "the unit manager is really good".

Peoples views were gathered through an annual survey completed by an independent company. We reviewed the results of a survey completed in Autumn 2013 with results published in January 2014 based on 32 responses. We saw that an action plan was in place for identified issues such as activities, refurbishment of rooms and the garden.

We saw varying leadership styles on each unit which had different impacts to people using the service. We observed that the care provided on two units with enthusiastic leaders was of a better standard than on other units where leadership was not so good. These two units appeared better organised and clean on 30 January 2015. Although staff were aware of their roles and responsibilities they delivered them differently. On the other two units, care staff were very task oriented and did not always remember to include people when carrying out tasks such as updating records. Attention to detail such as brushing people's hair and ensuring they were dressed properly was lacking. However, on 9 March 2015 when unit leads were present, all four units were better organised with people looking groomed. This meant that people were not always cared for consistently, involved in their care and their dignity was not always protected. When we asked the manager about this we were informed that two of the unit managers were on holidays on 30 January and junior staff were deputising in their absence.

There were ineffective systems in place to monitor aspects of the quality of care delivered. Although there were regular quality audits which included daily checks of 10 Mars sheets, monthly audits of documentation and infection control. The infection control audit and documentation audit had failed to address concerns related to cleanliness, infection control and accuracy of peoples records we found on our visits.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 (2) (a)and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The values of the service were the generic BUPA values and vision. Although the values emphasised person centred care, staff could not always demonstrate what these values were and how they applied to their daily work. Senior staff were aware of the values and vision of BUPA. Although we were told that staff were made aware of BUPA's values and vision in induction they did not demonstrate awareness of these values despite them being displayed at the main entrance 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
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not always have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 11 (3)

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 registered person did not so far as reasonably practicable, ensure that people who used the service were protected from infection. There were ineffective systems to assess the risk of and to prevent, detect and control the spread of a health care associated infection. Appropriate standards of cleanliness and hygiene in relation to premises occupied for the purpose of carrying on the regulated activity were not maintained. Equipment and reusable medical devices used for the purpose of carrying on the regulated activity were not always cleaned appropriately between each use. Regulation 12 (1)(e) (2) (a)(b)(c) (e) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Action we have told the provider to take

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 systems in place to assess, monitor and improve the quality and safety of the services were not always effective. Systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users had failed to address shortfalls related to infection control and care planning. Regulation 17 (2) (a)and (b)
	The registered person did not always make suitable arrangements to ensure the dignity, privacy of service users. People were not always treated with consideration and respect. Regulation 10 (2) (a)