GCH (Alan Morkill House) Limited

Alan Morkill House

Inspection report

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Ratings

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

Overall summary

In December 2013 we inspected the service and found that it was meeting all of the regulations checked. Improvements had been made in the areas of care planning, nutritional and pressure ulcer screening, activities provided, staffing levels and staff training.

This inspection of Alan Morkill House took place on the 18 and 20 November 2014. On the first day we arrived unannounced; on the second day staff were expecting us.

Alan Morkill House provides residential care for up to 49 older people, many of whom are living with dementia or severe and enduring mental ill-health. Most people stay long term, a few are there for shorter periods for respite care or after hospital stays. The home has four floors and people occupy small flatlets organised into seven units. There is one unit on the ground floor and two units on all the other floors. Although each person has their own shower room and small kitchen area, the kitchen areas we viewed were unused. Meals were provided from the main kitchen with snacks and drinks available from the kitchenette on each unit. Previously the building was used to provide sheltered housing.

Summary of findings

The post of registered manager had been vacant since August 2014, but the provider was trying to recruit to it. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that care staff were kind and polite. They respected people's rights and were well-meaning. However, they focused almost exclusively on meeting people's personal care needs and their social and emotional needs were regularly overlooked. Group activities were well attended and enjoyed, but there was little consideration given to individual leisure pursuits other than watching television, unless people initiated it themselves. The service was increasingly caring for people with complex needs and we found evidence that it was ill-equipped to meet some people's needs in terms of staffing levels, training and experience.

There was a lack of attention to detail at all levels throughout the home. This impacted on people who used the service as they were cared for in an environment which was neglected in some areas. In addition, they had little mental or physical stimulation, unless they chose to attend the daily group activity or had a visitor. The management team was insufficient for its remit and this contributed to a lack of supervision and monitoring. Audits were ineffective, in particular in relation to infection prevention and control.

These issues amounted to a breach of the regulations for cleanliness and infection control, care and welfare and assessing and monitoring the quality of service provision. 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. Poor storage of disposable gloves and aprons compromised infection prevention and control measures and some areas of the building were dirty and had an unpleasant odour.

People using the service had more complex needs than those who had lived there in the past, but the staffing levels and skill mix had not been developed to reflect this.

Staff were aware of their safeguarding responsibilities and reported any concerns. Those who administered medicines knew how to do it safely.

Is the service effective?

Requires Improvement

The service was not fully effective, because there was a lack of attention to detail when attending to people's needs and the premises needed some more signs or other indicators to help people to find their way around.

The home carried out its duties in relation to the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DoLS). DoLS ensure that people's freedom is restricted only if there is no other way to protect them from harm. If people had capacity to make decisions for themselves, their wishes were respected.

There were strong links with healthcare professionals which benefitted people who used the service.

Is the service caring?

Requires Improvement

Aspects of the service were not caring. Whilst staff members were kind and polite, there was not sufficient attention paid to engaging with people who used the service, especially if they had communication needs, to demonstrate the service as a whole was caring.

Bedrooms were personalised to reflect the interests of individuals.

People were consulted about their care on admission, but they were not routinely involved in planning it once they had moved in.

Is the service responsive?

Requires Improvement

Some elements of the service were not responsive. Whilst group activities were popular and well attended, there were few opportunities for people to pursue any meaningful activity within the units if they needed staff support.

People's social and emotional needs tended to be overlooked unless people were actively distressed. Physical care was prioritised.

Summary of findings

Assessments and care plans were in place, but would benefit from more detail and input from people who used the service and their relatives, when appropriate.

Is the service well-led?

Inadequate 

The service was not well-led. Internal audits were not effective as they did not uncover some of the issues we identified.

The management team was insufficient to meet its remit and management duties had to take second place to supporting people who used the service when they were upset.

Management records, such as those for fire safety, were not always well maintained or organised in a way that was easy to follow.

Alan Morkill House

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 checked 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 18 and 20 November 2014. On the first day we arrived unannounced; on the second day staff were expecting us, but did not know we would arrive in the late afternoon in order to observe care during the evening and the start of the night shift.

The inspection team comprised an inspector and a specialist professional advisor, who was a qualified nurse and an expert in dementia care. We were observed and supported by a member of the Care Quality Commission's communications team.

The provider had submitted a Provider Information Return (PIR) which we found to be factually correct when we checked. A PIR 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 were able to speak to one commissioner of the service prior to the inspection who was generally positive about the care provided.

During our inspection visit we observed staff and people who used the service, especially those who could not directly express their views to us. We spoke in detail with five people who used the service and briefly with more than 10 others, four of their friends and relatives, four members of the management team, nine care workers and the handyperson, as well as one member of a multi-disciplinary team involved in a falls prevention pilot project within the home. We checked a wide variety of records kept by the home, including six staff recruitment files, the medicines administration records for one floor and five care files. We also observed a shift handover meeting.

Inadequate

Is the service safe?

Our findings

Processes to minimise the risk of infection were undermined by the inappropriate storage of personal protective equipment (PPE). We found disposable aprons stored in disused dishwashers amidst food particles and soap scum. Apron rolls were also kept on draining boards in sluice rooms, which may or may not have been decontaminated. Although staff told us they had easy access to disposable gloves of all sizes, when we looked we could only find one box, size medium, in the kitchenette of each unit. There were insufficient laundry trolleys and we observed one member of staff dragging laundry bags along the corridor. We saw staff washing their hands frequently, however, some staff told us they also liked to use alcohol gel hand rub. They brought their own to work as it was not supplied. Use of this can prolong the effects of hand washing, but it is not a substitute for it.

Maintenance of the premises kept most of the building in reasonable condition and there was a cleaning schedule. Lighting in some bedrooms was very dim and could not be adjusted which may have hindered thorough cleaning. In some areas there was a strong smell of urine and some net curtains, carpets and light switches were dirty. In addition we found some chairs were unclean, sealant was cracked and gaping and a few areas were hard to clean due to damage. The manager told us that the worst area, a kitchenette worktop, was due to be replaced.

The ground floor kitchenette fridge was missing the door of its icebox so water was dripping on to the food stored below. We were unclear how fridge temperatures were being monitored in the kitchenettes. Although staff assured us that they were doing this, records were not to hand in at least two of the kitchenettes. In addition, one fridge contained three thermometers, each displaying different temperatures. We noted that the main kitchen had received five stars for food hygiene which was the top score. We could not view the food storage arrangements in the main kitchen during our evening visit as the key to the fridges was not available, but the rest of the kitchen looked very clean and we saw that there was an appropriate cleaning schedule in place.

Some people were sleeping on divan beds. Whilst the mattresses were protected, if required, the base units absorbed any liquids which trickled down. This was contributing to the unpleasant odour in some rooms. We also found one bed where the protected mattress cover was slippery and liable to move. The mattress was partially off the divan base when we viewed it. A visiting member of the multi-disciplinary team told us that hoists and slings were not always kept clean.

We found that appropriate standards of cleanliness and hygiene were not maintained in relation to both premises and equipment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Several people who used the service said it was under-staffed, a typical comment was, “I wish there were more staff”. One person said, “I don’t know how [the staff] manage.” One visitor said they came daily to help their friend to get ready for bed as staff were too busy.

When we looked at the staff rotas for four weeks we saw that these supported what staff and management were telling us about the number of people on duty. No agency staff were used which improved continuity of care, but some people who used the service and their relatives told us that it had been a struggle to fill all shifts during the summer and, occasionally, a shift had been short-handed. Staff members confirmed this. The provider was continuously recruiting to fill vacancies.

Staffing was set at a level to meet people’s basic personal care needs and did not take into account factors such as the additional encouragement and support they may require to complete tasks or to engage in other activities. Staff told us they rarely had enough time or staff resources to take people to the park over the road. One member of staff said, “We can’t take out people with behaviour that challenges unless a family member is [also] present.” With regard to personal care, a relative said, “Family members have to support [people with their care].” Other staff told us they were worried about leaving people unattended in the lounge when they had to support people in their bedrooms.

We observed one person who did not want to undertake their personal care at the time suggested by staff. We saw that the one staff member on the unit did not get the chance to offer the person support again before the end of the shift. We read a complaint from one relative about the length of time their family member, who needed significant support, was left in bed in the morning. One person we observed during lunchtime was totally reliant on staff help

to eat their meal, but the staff member responsible for assisting them had to attend to other people too, so this person experienced three interruptions and a change of staff during their lunch.

Most staff we spoke with explained that the service was now providing care to an increasing number of people with complex needs on account of their dementia or mental health. We did not find any corresponding increase in training or support for the staff team to enhance their skills and knowledge in these areas. A multi-disciplinary team was supporting Alan Morkill House as part of a pilot project and we saw that this had improved monitoring and intervention in relation to falls prevention, but we did not find that the staff were equipped to respond to mental distress or behaviours which challenged. For example, someone was admitted to the home from hospital in the midst of our inspection. All that staff had to guide them was a mental health assessment which had been written in February 2014. This did not contain sufficient information about how to respond to behaviours which the person was known to display. When we asked two senior staff what they would do if the person became distressed, they separately told us they would "call the doctor". They were unable to describe any other appropriate course of action. A recent report in relation to one person who used the service and prepared by a healthcare professional contained the sentence, "It was pretty clear some staff find it difficult to manage individuals with dementia in terms of understanding the nature of the illness."

We did not find any evidence that staffing levels had been reassessed to take account of the changing needs within the home, despite dependency levels being assessed monthly. The provider failed to ensure that sufficient skilled and experienced staff were employed to meet people's needs. For example, no provision had been made to ensure a person recently admitted to the home after a long stay in hospital was supported by staff with knowledge of their needs or the skills to deal with the risks that could have arisen.

We found that staffing arrangements did not protect people from the risks associated with inappropriate or unsafe care because care was not able to be delivered in such a way to meet people's individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at staff recruitment files for staff recently employed and saw that safer recruitment practices were being followed. The manager had been on advanced training in this area and the deputy manager said they received good Human Resources (HR) support if they were unsure about some aspect of recruitment, for example, visas.

There were appropriate safeguarding arrangements in place and good working relationships had been established with local authorities and healthcare professionals. Most staff had received training in this area and were able to tell us some of the basic signs of abuse they kept an eye out for. They said they would feel confident in approaching senior staff if they had any concerns for a person's safety. One member of staff said, "I speak my mind when it comes to protecting people."

The provider's own records showed that seven safeguarding concerns had been substantiated since April 2014, this did not reflect well on the quality of care in some cases. In addition, staff told us that, on occasion, the actions of some people who used the service had scared them. We brought this to the attention of the deputy manager and they assured us that this issue was linked to one person who used the service and they were now receiving support from the community mental health team which had resolved the matter. We saw that accidents and incidents were logged appropriately, there was evidence of learning from falls, but less evidence of learning or improvements following other incidents.

We reviewed the arrangements for administering medicines on one floor and found that a monitored dosage system was in place. We observed a member of staff who was responsible for making sure that people received their medicines at the right time. The staff member waited very patiently for each person to take their medicines in their own time before signing to confirm the tablets had been administered and did not attempt to rush them in any way. We found that the standard of recording was good, despite the pharmacy not aligning the dates with the columns on the printed medicines administration record (MAR). We asked the manager to raise this with the pharmacy as it increased the risk of error. The number of tablets in stock for each person was accounted for each day. An extra cross-check that the provider required was not always happening at the frequency indicated in their policy. This involved MAR sheets being checked after each round by a

Inadequate

Is the service safe?

competent member of staff from another unit and then signed off by a senior member of staff. However, from the records seen, this was not affecting correct administration of medicines.

The third floor medicines room was consistently recording a temperature which was too high for the safe storage of some medicines. We saw emails which showed this was regularly raised with head office, but there had been no response, neither had a temporary alternative arrangement been made.

The fire and gas safety log was not well organised, therefore, it was hard to ascertain if all the necessary checks and certificates were in place. We asked the manager to confirm that the required work had been undertaken on the gas hob in the kitchen and that fire checks were taking place weekly as the most recent entries were missing. We saw that remedial works arising out of a fire safety order were well underway, completion was required by 7 December 2014.

Requires Improvement

Is the service effective?

Our findings

It was difficult to tell whether or not staff had undertaken all appropriate training for their role as the training matrix spreadsheet was not up-to-date and it had been constructed to flag up the need for refresher training after a year, even though some courses did not require a refresher. It also contained the names of people who had left the service. However, we saw that mandatory training courses were provided and most current staff were up-to-date with the majority of them. Additional short training courses were available to staff, such as one on dementia care. The manager showed us the arrangements they were making for safeguarding and fire safety refreshers. The director of nursing said the provider had plans underway which would improve current dementia training. The provider offered staff the opportunity to acquire vocational training and employed an external provider to support staff with this. Staff told us that training was "good", but they needed more than "awareness" training in areas such as mental health.

We found a general lack of attention to detail within the home in relation to both the people who lived there and the premises themselves. For example, one person had problems lifting their arm, yet they were dressed in a top that required them to lift their arm to dress or undress. Other people would have benefited from simple communication aids, but did not have any access to them. Curtains were hanging off rails, some net curtains were ripped, a plant was tied up using disposable gloves, chairs were not always positioned to enable people to interact and there was nowhere for anyone to rest when walking along the corridor. Signposting was very poor within the home, it was not always clear which floor you were on or which unit. Many doors were not labelled with people's names or the function of the room, yet this could have helped people new to the building or those with memory problems.

Some improvements had taken place, the provider had recently installed a new call bell system throughout the service. When we visited people in their rooms we saw the bells were close at hand so they could easily summon assistance. The internal walls were being gradually repainted.

Good practice guidance was not readily available within the home for staff to refer to. When general guidance was available, for example, information about assisting people to eat and drink was pinned to a staff notice board, we found that staff were not always following it. We observed they failed to turn off noisy distractions, such as the television, when people were eating.

There were good links with local healthcare professionals, as demonstrated by the home's involvement in a multi-disciplinary pilot project, but we found that one person had waited far too long to be referred for tests. Therefore the system for identifying such matters was ineffective. Several staff described improved access to psychiatric services following a change in local NHS personnel.

The manager and deputy manager had a good understanding of their responsibilities in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). We saw that people who had been assessed to have capacity to make their own decisions were not restricted in their life-style choices. There was written evidence showing how a staff member had been corrected when they had mistakenly told a person who used the service that they could not follow their personal lifestyle choice within the home. We also saw a risk assessment which showed that a person with capacity to make their own decisions was supported to go out alone, even though they were at risk of falling. Measures had been taken to reduce the risk.

When people were assessed as being unable to make some decisions for themselves we saw that applications for DoLS had been made. Some people were at risk of harm if they accessed the kitchenettes on their own. The provider had fixed an unobtrusive catch on the relevant doors which prevented this from happening. We asked the manager to review whether or not the other people who used the service were aware of how to open the catch. If they were not, it would restrict their access to the kitchenettes too. Although care staff had received training on DoLS, they saw them as negative, rather than as a way of ensuring that people's human rights were restricted as little as possible to keep them safe.

We observed lunch in three of the units. Food was appetising and a choice was offered. Two people told us, "The food's very good." They also said there was plenty of it. One person did not agree. There was information about people's individual eating and drinking needs and preferences in each kitchenette. In one unit we saw that

Requires Improvement

Is the service effective?

inside the kitchen cupboards there was a photo of each person with instructions about how to make their tea. A few people from different backgrounds mentioned to us that that they were only supplied with foods from their culture as a special treat, rather than routinely. However, staff told us that the new cook was responsive to people's needs and asked for feedback about the food provided, so they were confident this could be addressed.

People's nutritional needs were screened on admission and the provider's form indicated that they needed to be reassessed if their monthly weight fluctuated by more than three kilos. We saw that this had not happened in the case of, at least, one person.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were kind and polite and our observations confirmed this. At lunchtime we saw that many staff were friendly and attentive. Two people said, "The staff are kind." Two more people gave us the 'thumbs up' sign when we asked them. There were two dissenting voices. One person mentioned that a few staff members had no idea how loud their voices were. Another said, "You have to be outspoken about your needs [to get them attended to]." A healthcare professional who visited regularly said that staff were "responsive" when healthcare staff made requests. They also said that "staff genuinely care".

With some notable exceptions, many staff members carried out their work silently except for making polite requests or announcements to people who used the service. We observed few conversations between staff members and those who used the service; opportunities were, therefore, missed, as informal conversations can help to orient people to place and time, let staff explore the person's mood and preferences, as well as making people feel valued as individuals. There were no communication aids in use.

A strength of the home was the attention paid to personalising people's bedrooms. In other areas more attention to detail was required, for example, one person's care plan said they wore glasses and needed support to have them to hand at all times. We did not see this person with their glasses at any time during our two day visit, they were even without them in the photo on the cover of their care plan.

In one person's file a relative had completed a "This is Me" document, which had been developed by external organisations. This provided a compassionate and affectionate account of the person's life and current needs in a way that other documentation did not. We saw that people had been consulted about their care prior to admission, but there was little evidence that people, or those who mattered to them, had been routinely involved in identifying their changing needs or planning their own care once they had moved into the home.

Staff asked people for their agreement before they carried out their personal care. We noted that they took care to respect people's privacy and dignity, helping them to discreetly adjust their clothing to protect their modesty and keeping bedroom doors closed when delivering personal care. However, one member of staff was observed to speak about people's needs in front of people who used the service, this showed us that people's privacy and dignity was not always respected within the home.

Requires Improvement

Is the service responsive?

Our findings

When asked about the service one person told us, "It is fine, so long as you learn to fit in with the home's routine." We found little involvement of people in reviews of their care plans. In most cases this was an exercise carried out by a senior member of staff on their own.

We observed that staff were fully occupied carrying out personal care tasks, most staff members spoke about this as their main (or only) role. One member of staff said, "The passion for me is dressing the residents." As a result, people looked well cared for physically and this was supported by records. A healthcare professional described good practice in reporting deterioration in mobility and responding to falls.

People's individual social and emotional needs tended to be overlooked, unless people were actively distressed, in which case staff members were quick to comfort them. For example, we did not see any attempts to engage people in activities unless they joined in a planned group activity led by the activities coordinator or an external organisation. There were no games, books, memory boxes or similar readily available in the communal areas of the home, only televisions which were always on and the occasional free newspaper. One person said, "I only get to see a newspaper sometimes. I wish it was more often." Staff told us that it was difficult to keep things in the communal area as one or two people hid them, but this meant that everyone was deprived of things to do. We did not see people being encouraged to interact with each other, although sometimes this happened spontaneously and could have been built upon.

When we looked at some pre-admission assessments of needs, we found they lacked detail and contained significant gaps. Some people had a lot to tell us about their life history, but little of this was written down so staff could only find out by asking people.

The care plans we viewed addressed people's individual needs and the language was non-judgemental. However, the format was complex and required cross-referencing, so we found instances where the information had been updated in one section, but not in another. They did not always give a good overview of people's healthcare needs as the information was scattered across several sections. The director of nursing told us new style care plans had been developed which would address these issues and they were due to be signed off for use imminently.

We observed that some people who used the service lacked motivation to attend to their personal care needs and engage with others. Staff made polite requests, but sometimes lacked the skills to motivate people. This was demonstrated when a staff member offered medicines to a person who tended to refuse them. The polite request was refused, but staff did not try to engage the person further.

The planned group activities were very popular with many of the people who used the service and the part-time activities coordinator kept brief, but informative, records on the quality of people's participation, as well as their non-participation. From these records, patterns of participation were identified and it was clear that the activities coordinator was using this information to better engage people. We saw that one person was regularly invited to join a group, but preferred to do their own thing until they were invited to choose a film for cinema night. The same person was keen to talk about an interest of theirs and this was also picked up on by the activities coordinator. We saw a well-attended Tai Chi (a gentle martial art) group in progress run by an external facilitator. The people we spoke with about it told us they enjoyed the session, one person said, in relation to physical activity, "If you don't use it, you lose it. That's why I go." The home was advertising for a full-time activities coordinator.

Inadequate

Is the service well-led?

Our findings

Staff on-site carried out some audits and we were told that outcomes were monitored by the provider's head office. We did not find any evidence that this monitoring had resulted in service improvement plans specific to the home. Some of the in-house audits carried out were not effective as they did not pick up on problems. For example, the medicines audit failed to identify that cross-checking was not taking place consistently and the health and safety audit did not identify infection prevention and control storage issues. We could not find medicines audits for May, June and August 2014. Despite the issues we had noted, when we looked at the home's "Take 10" record (a regular briefing for senior staff) for 3-21 November 2014 we found little evidence that managers were aware of many of them.

The leadership within the home was very stretched and was only having a limited impact on how the home was run. This had not gone unnoticed by people who used the service or their families and friends. A typical comment was "I wish they'd [the provider] sort out the management." They described a management team which was not on top of things. We found that some major issues had been dealt with effectively, such as GP cover, but there were too many areas requiring attention for the small management team to address without support from head office. Senior staff were called upon to help out in the units when extra staff were needed, for example, to support a person in distress. Whilst the staff team praised local management's responsiveness to requests to help out with direct care, this required them to drop their supervisory and monitoring duties and there was no one else to pick them up. Staff members were, therefore, doing what they had always done, despite management instructions to implement new ways of working. This was evidenced by staff meeting minutes, as management requests in meetings were not always translated into the practice we observed and there were few systematic checks to ensure changes had been made.

Records suggested that staff meetings were infrequently held, although the temporary manager had called one to explain the new cover arrangements. Staff members told us meetings were not always minuted. Staff lacked support to apply any lessons learned during training. Supervision records and staff accounts of supervision were variable, but some staff described regular supervision sessions in which their strengths and weaknesses, people's individual care needs and staff training needs were discussed. An appraisal system was being implemented. We sat in on a shift handover meeting. We found that there was little opportunity for staff to discuss individual people's changing needs in detail and how to meet them.

There had been a high turnover of staff in recent months within both the home and the provider's head office. Several people, their relatives and friends told us they were upset about this. A person who used the service said, "I am having to train people about my needs all over again." There was no registered manager in post, although a registered manager from another of the provider's homes was providing some part-time cover and was present in the home more than once a week. The provider had been let down by the successful applicant at the last minute, so had to re-start the recruitment process. Managers told us it was difficult to attract staff as "no one wanted to pay to travel into central London". There was no plan in place to address this issue.

We found that systems in operation to identify, assess, monitor and address the quality of services provided were not effective. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Many of the documents on the shelves in the manager's office and the seniors' office were out of date, for example, those relating to the Care Quality Commission, and/or unordered and/or unlabelled. This made them hard to follow. Also some folders related to work completed several years ago and should have been archived to minimise confusion and to ensure current records were more accessible.

One relative told us that the provider had not kept proper records of fee payments made. The same issue had been logged as a complaint by another relative. They said they had always paid promptly, but had been issued with reminders. In the end they had had to supply bank statements to show that bills had been paid. We saw written evidence which showed this issue had been resolved and the provider now accepted the payments had been made.

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 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Service users were not protected against identifiable risks of acquiring infections as appropriate standards of cleanliness and hygiene were not maintained in relation to both premises and equipment. Systems in place to assess the risk of and prevent, detect and control the spread of infection were not operating effectively. Regulation 12 (2)(a) and (c)(i)(ii)

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services 9 (1) The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of— (a) the carrying out of an assessment of the needs of the service user; and (b) the planning and delivery of care and, where appropriate, treatment in such a way as to— (i) meet the service user's individual needs, (ii) ensure the welfare and safety of the service user. **Regulation 9(1)(a)(b)(i)(ii)**

The enforcement action we took:
A warning notice was issued requiring the provider to be compliant with the regulation by 30 January 2015.

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 10 (1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to (a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and (b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

This section is primarily information for the provider

Enforcement actions

(2) For the purposes of paragraph (1), the registered person must—

(b) have regard to—

(i) the complaints and comments made, and views (including the

descriptions of their experiences of care and treatment) expressed, by service users, and those acting on their behalf, pursuant to sub-paragraph (e) and regulation 19,

(iii) the information contained in the records referred to in regulation 20,

(c) where necessary, make changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a registered person should be aware, relating to—

(i) the analysis of incidents that resulted in, or had the potential to result in,

harm to a service user, and

(e) regularly seek the views (including the descriptions of their experiences of care and treatment) of service users, persons acting on their behalf and persons who are employed for the purposes of the carrying on of the regulated activity, to enable the registered person to come to an informed view in relation to the standard of care and treatment provided to service users.

Regulation 10(1)(a)(b), (2) (b)(i)(iii), (c)(i), (e)

The enforcement action we took:

A warning notice was issued requiring the provider to be compliant with the regulation by 30 Jan 2015.