Sohal Health LLP

Chalkney House

Inspection report

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Ratings

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

Overall summary

The inspection was carried out on the 11 November 2014 and was unannounced.

We last inspected this service in July 2014 to follow up on enforcement action we had commenced in May 2014 with regard to poor care and welfare of people using the service. During our inspection in July 2014, we noted the home had made some improvements but we still had some concerns. We followed these up as part of this inspection and the required improvements have been made.

Chalkney House provides accommodation for up to 47 people who require nursing or personal care. On the day of our inspection there were 36 people living at the home some of whom had dementia.

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

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 and associated regulations about how the service is run.

CQC is required by law to monitor the operation of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions for themselves and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others.

The service was acting lawfully to support people around decisions about their care and welfare.

At this inspection we identified poor systems around the safe storage and administration of medicines. This meant we could not be assured that people received their medicines safely. 'You can see what action we told the provider to take at the back of the full version of the report.'

The home was clean and in good decorative order. However we identified concerns with infection control practices which could increase the risk of acquired infections spreading from one person to the next.

There were sufficient staff to meet people's needs because the manager showed us the staffing rotas which matched the number of staff working. Staff were attentive to people and met their needs in a timely, appropriate way.

Improvements were needed in the way the provider assessed staffs competency, and evaluated staff training to make sure it was effective. Training records were not up to date and for temporary staff there was no induction records so we were unable to see that all staff had sufficient experience or skills to perform their role.

Staff were kind and caring to people using the service and regularly engaged with people thus promoting their sense of well- being. People had sufficient to eat and drink for their needs and staff encouraged and supported people at mealtimes.

Records told us about people's needs and how they should be cared for. However we found improvements with record keeping was required because they were not always up to date. Staff spoken with demonstrated a good knowledge about how to care and support people. People we spoke with said they were well cared for and we observed care being provided which was in line with people's plan of care.

The manager was proactive in managing complaints and reporting any concerns about people's well-being to the local authority. We saw this from their records and had spoken with staff from the Local Authority who told us the manager reported concerns as appropriate.

Improvements were required in the way the home was managed and the service delivered. Audits did not always identify deficiencies in the service delivery or clearly show what actions had been taken to address these shortfalls. This meant the auditing process was ineffective and we could not always see how the service addressed people's views and needs.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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?

Requires Improvement

We assessed the service as unsafe.

Unsafe practices in the administration and storage of medication were identified and could place people at risk from receiving the wrong medication or not as prescribed.

Infection control procedures were adequate but required improvement to further reduce the risk of cross infection.

Staff had received training so they would know what actions to take to safeguard people from harm and, or abuse.

Is the service effective?

Requires Improvement

We assessed the service as ineffective.

Staff received training but we could not be assured training was adequate or staff were supported sufficiently to carry out their roles effectively.

Staff assessed people's needs and provided support accordingly. Through observation we saw people received the support they required to eat and drink in sufficient quantities.

People's health care needs were met and care was provided according to people's expressed wishes.

The manager understood legislation relation to the Mental Capacity Act and Deprivation of Liberties safeguards and acted according to the law.

Is the service caring?

Good

The service was caring.

Staff were kind to people and spent time reassuring them.

People's independence was promoted and where people required assistance with their care needs this was provided in an appropriate, consultative way.

Families were consulted about the service provided to their relatives and people were asked how they wished their care to be provided.

Is the service responsive?

Good

The service was responsive.

People were consulted about their care. There was an effective complaints procedure which helped the manager identify where improvements to the service and people's care were needed.

Summary of findings

People's needs were kept under review and care plans showed staff how to meet people's planned needs and how to act responsively where a person's needs had changed. Risks to people's safety were known and steps were taken to reduce the risk, particularly in relation to falls.

Staffing levels were provided according to people's needs. Staff were given training to enable them to respond appropriately to people's needs.

Is the service well-led?

Requires Improvement

The service was not well-led.

Audits were undertaken to judge the effectiveness and the quality of the service provided. These took into account the views and experiences of people who used the service. However the audits were not always effective.

There were systems in place to assess, monitor and reduce risks to people's safety and promote their health and welfare. These were not as robust as they should be because record keeping was poor.

Chalkney 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 was planned to check whether the provider was 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 11 November 2014 and was unannounced.

The inspection team consisted of two inspectors and a specialist advisor who was a registered nurse.

Before the inspection we reviewed the information we held about the service including recent inspections, complaints, safeguarding and comments from people who shared their experience with us. We also reviewed notifications received from the home. A notification is used by the home to tell us about events affecting the well-being and or safety of people using the service.

Before the inspection, we asked the provider to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

We spoke with two night staff; three ancillary staff, three care staff, two senior care staff, the activities co-ordinator and the registered manager. We spoke with 13 people using the service, two relatives and observed the care provided to 15 people. We looked at seven care plans and other records such as medication records and audits around the safety and suitability of the service and in particular the management of falls.

During the inspection we used the Short Observational framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We carried out a SOFI observation during lunchtime.

Requires Improvement

Is the service safe?

Our findings

Medicines were not stored safely. Medicines were delivered into the office which was unlocked and unattended at times throughout the day. We saw that unauthorised persons could access the medicines from the office following delivery or other times of the day because the person a administering the medicines did not keep the key with them at all times.

Where people were prescribed medicines when required such as for pain relief. Not everyone had guidance in place as to when they should be administered. This meant people might not get medicines when they needed them.

There were inconsistencies on the medication administration record, (MAR) and the person's care plan. Changes to medication did not always result in care plans being updated. Therefore there was not an accurate list of prescribed medications kept for people. There was a risk that if a person needed to transfer to another service it would not be clear what medication they required which may result in incorrect administration.

Mar charts were not always signed in line with safe administration guidelines. We saw that medicines had been administered and there was no record of this. People's care plans did not always record risks to medicine administration such as choking and prescription creams were not always signed for. This meant that people were not always protected from the risk of unsafe administration of medicines as records were not accurate.

Where people had been prescribed antibiotics it was not always clear, what these were prescribed for or what the contraindications could be. For example some medicines might increase people's risk of falls and this information was not available to staff. Staff were unable to describe what the risks of some medicines were and how this may impact on the people they were prescribed for.

Medication audits had last been completed in May 2014 and highlighted that a weekly stock check should be completed. However it had not been. This meant that discrepancies we identified had not been identified by the manager. Audits were ineffective at identifying these concerns. People were at risk of unsafe administration of medicines.

This was a breach of Regulation13 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

We were told about an incident where the manager had identified poor manual handling practices within the home. The manager took the appropriate action and notified external agencies and CQC about the concern. They took the appropriate action through supervisory processes and retrained a number of staff. However the manager told us that they had not carried out any direct observation of care since the incident to ensure the training had been effective and that people were not at risk

On the day of our inspection the home was well staffed. We saw that people were regularly checked to ensure they were safe. We saw that staff were accessible to people all of the time. We saw a number of examples were staff were available to intervene where required. For example, we saw a person prone to falls attempting to get themselves out of their chair; they did so in an unsafe way and were unsteady on their feet. Staff stepped in to support and reassure the person and prevented them from falling. Another person became quite upset with the person next to them when they accidently touched them. Staff stepped in and quickly diffused the situation to the satisfaction of both parties.

The provider had introduced a dependency tool to enable them to calculate how many staffing hours they needed each shift to meet the needs of the people using the service at any one time. This tool was kept up to date and we saw that staffing levels were being provided according to the tool.

We spoke with staff who told us there were enough staff. We spoke with night staff who told us staffing levels increased according to the number of people they had and their assessed needs. People spoken with said there were enough staff which enabled them to have a flexible routine to suit them.

We spoke with people about their safety and all but one person told us they felt safe and trusted the staff. One person told us staff checked on them at night at least three times, but said new staff did not always introduce themselves and they felt anxious about this. We established that they had a visual impairment and were not able to recognise who was attending to them. We raised this with the manager so they would be able to address this with all staff. We looked at another incident where a person

Requires Improvement

Is the service safe?

had been subject to abuse by another resident. This was well managed by the home and could not have been foreseen, steps were taken immediately to protect the person against any further incidents.

Staff spoken with had received safeguarding training and were able to tell us what abuse was and how they would protect a person from harm. Staff also knew who they could contact outside of the service if they felt their concerns were not listened too. We noted that there was information available to staff and others showing what actions they should take if they suspected abuse. Staff said they felt people were safe and well looked after. The manager reported concerns about people's health and welfare to the Local Authority and was able to give us examples of what they had reported and the internal investigations they had completed when asked. These were sufficiently robust and included conclusions and good practice recommendations. This meant they learnt from incidents to reduce the likelihood of them happening again.

We looked at the arrangements in the home to minimise the risk of infection because of a recent outbreak of sickness. This was the second outbreak this year affecting a lot of people whose health was already compromised making them more vulnerable to infections People told us that the home was, "clean and tidy." One person said, "My room is absolutely spotless." There were three domestic staff working on the day of our inspection and we found the home to be clean. Domestic staff told us that they were able to cover different areas of the home and carry out deep cleaning of the different areas of the home and people's bedrooms when required.

Infection control audits were completed every six monthly. A recent outbreak of infection at the home had not resulted in an audit of the infection control measures to ensure their procedures were adequate. We looked at the last infection control audit which had not identified any issues or concerns. We found that waste products were put in ordinary bins, which were not pedal bins. This meant there was a risk of contamination from soiled products as staff's hands were coming into contact with the bin lids. We noted people did not have individual manual handling slings and the manager told us these were washed weekly by the night staff but there was no record of this kept. This meant we could not be sure this happened in practice and could place people at increased risk of cross contamination.

The laundry room was very small and although the clean and soiled laundry was segregated they were both in the same coloured bins which could mean soiled laundry could be mixed with clean. Cleaned and ironed clothes were stored next to soiled laundry so there was a risk of cross contamination.

We identified inconsistent practices around the use of gloves and aprons. Some staff wore gloves and aprons and others did not. Staff should wear appropriate protective clothing when carrying out personal care to ensure the risk of cross contamination is minimised. Staff were unsure when they should wear gloves and aprons to protect themselves and people using the service. People were at increased risk of infection spreading from one person to another.

This was a breach of Regulation 12 of the Health and Social

Care Act 2008 (Regulated Activities) 2010.

Requires Improvement

Is the service effective?

Our findings

We saw staff responding to people's individual needs. Staff were aware of what people needed and discussed with them topics of interest such as their childhood and places they had visited. One person had limited communication and became frustrated when they could not make their needs known. We observed staff supporting this person appropriately with their communication and frequently making eye contact, offering reassurance and responding to their requests. Staff gave them the time they needed. The person's relative praised staff and the care given to their relative. We observed staff skilfully meeting another person's needs at lunch time, supporting the person with their meal at an appropriate pace and ensuring they swallowed each mouthful before proceeding.

Staff training was planned in an ongoing way and staff had received supervision. However the manager told us they had been unable to complete staff supervision as often as they would have liked and this was something they were addressing when they had the new deputy manager in post. They were due to start in a couple of days. The manager had started doing care observations which she said she would use as part of staff supervision. We spoke with staff. The newer staff did not have a clear concept of supervision but each member of staff said the manager was approachable and worked alongside them on shift. Each felt that supervision was provided each day and was informal. Recording this would support the manager to supervise staff effectively.

Staff confirmed they had received the training required for their role. Some staff told us training was provided every month. However this was not always recorded on the training matrix. The manager told us external training providers were sourced but training was not always service specific. The manager did not assess staff competency formally following the training or get any formal feedback from staff on how the training supported the in their role.

The manager told us they supported staff to undertake further care qualifications and the manager was encouraging staff to take lead roles, and to become champions for different areas of practice. This would enable them to build up their knowledge and act in an advisory capacity for other staff.

We found that there were processes in place to recruit and induct staff appropriately. However we had concerns about some staffs difficulty in communicating effectively with people using the service where English was not their first language. The manager assured us they were learning English but was unable to confirm if their command of English was sufficient to communicate with people, staff and the manager effectively.

We also had concerns about agency staff employed at night as the manager was not able to provide any documentary evidence of staff employed or whether they had sufficient skills to meet the needs of people they were supporting. There were no induction records for them or evidence their practice was monitored. Night staff told us they worked along- side regular staff. The manager had not asked the recruitment agency for documentary evidence that their staff had been recruited correctly and they had all the necessary checks in place for these workers. This meant we could not see that staff had the necessary skills, experience and credentials.

We observed staff offering people choice and gaining their consent before helping or assisting them with different aspects of their care. Staff told us they had received training in the Mental Capacity Act and Deprivation of Liberties safeguards. Staff were able to explain this and tell us how and to who they would report to if they suspected a person to be at risk of being deprived of their liberty or freedom. People's care records showed that assessments had been completed to assess if people had capacity to make day to day decisions. We saw records where a person's relative had given consent to care when the person was assessed as having the capacity to do so. The manager told us that in this case the person's capacity had changed but the record had not been updated. There was a risk that important decisions could be made incorrectly if people's capacity assessments are out of date.

People were supported to maintain good health. The manager told us that they had good relationships with the local GP surgeries. They also had regular access to a nurse practitioner who visited at least weekly. The nurse practitioner was visiting on the day of the inspection and told us that they were contacted regularly and were often at the home to support the manager and responded

Requires Improvement

Is the service effective?

quickly to any given situation One person told us, “My health is not bad but I have problems swallowing. The food is ok. They are liquidising it for me at present as I can’t swallow. I have two milkshakes a day.”

People had regular access to other health care services such as dentists, opticians and chiropody. Care plans identified how people’s health care needs were being met in both a planned and responsive way. We spoke with one person who had a skin condition. They said, “I have had a skin problem for years but since being at this home I have been visited regularly by the district nurses and for the first time in years my skin condition has cleared up.”

Lunch was provided in a timely way and, people were given a choice of meals. The chef served the food and knew people’s dietary needs. For some people they used food plates to show the different options and where people did not want their main meal other alternatives not available on the main menu were offered. We observed very little food wastage because people received adequate support and encouragement to eat their meal or offered something else where appropriate. The meals were reasonably sized and people were offered additional portions. We observed people enjoying their food and people told us the food was generally good. The chef had been at the home for many years and the style of cooking was described to us as, ‘old fashioned food.’

One person required full assistance and staff stayed with them until they had finished their meal. Throughout the staff member waited for the person to finish each mouthful and maintained the person’s dignity by wiping the person’s mouth in between assisting them with their food.

Risks to people in relation to food and drink were recorded and acted upon. We saw that people were weighed regularly. Where weight loss was identified the appropriate action was taken to promote weight gain. For example people were given snacks, milkshakes or where weight could not be maintained referrals were made to the dietician or GP.

Good

Is the service caring?

Our findings

We saw some good examples of caring practice. Staff were attentive to people's needs and we did not see people waiting for assistance. People's wishes were respected and people were assisted where required. We saw staff respond to people's feelings by sitting with them, offering them reassurance and checking on their well-being in a caring manner. We saw staff appropriately encouraging a person to mobilise. This took considerable time but staff at no point tried to rush the person, but reassured the person. We saw another person whose mood varied and staff adapted their approach accordingly. At lunch time a person needed a lot of encouragement to eat and staff were very patient and talked to the person about their food, likes and dislikes and when they became distracted from the task of eating staff reminded them what they were doing. We noted that staff were kind and reassured people. Where people did not initially understand what they were being asked, staff took the time to ask the question in a different way. One person found it difficult to verbally communicate and staff gave them the time they needed to make their request.

People were treated with respect and staff enhanced people's well- being by stopping to engage with people and knowing enough about people to meet their needs. For example one person prone to depression due to the sudden onset of illness was regularly supported by staff. Staff showed a genuine affection for them and regularly engaged with them, ensuring their comfort and wellbeing. Family members visiting expressed their satisfaction with the staff and praised the staff for their approach. We saw staff respecting people's privacy and dignity by knocking before entering their room and waiting patiently for a response when asking a question.

We saw that people were well dressed and well-presented. We saw that, in accordance with their wishes, some of the ladies had their nails painted and jewellery. Their hair was nicely done and people told us the hairdresser visited regularly. People were kept warm and we noted that some people had blankets wrapped around them particularly where they were sitting by doors which could be drafty. Blankets also helped promote people's dignity.

We noted staff respecting people's independence and encouraging people to walk where able and to retain the skills they had when they came to live at the home. We spoke with a person and their relative who told us they did here what they would do at home and another person said it took them along time to settle but now regarded this as home.

We saw staff asking people about their care needs and giving them choices about how they wished their care to be provided. Night staff told us people went to bed when they chose and got up according to their expressed wishes. We spoke with people who told us their needs and wishes were respected by staff. We saw some evidence of people being consulted about their care plans and giving their written consent to care.

The manager told us, "We invite families in and encourage them to participate in care plan reviews." Care plans had been reviewed but did not always show involvement with the person the care plan was about. However in some cases where it was considered the person was unable to contribute to their care plan staff told us they used direct observations to decide how the person would best like their care to be delivered. This was recorded in the person's care plan.

People had access to advocacy services and information was available about this. Advocacy was used to support people and their families when there were concerns about the service and the advocate was acting on behalf of the person using the service. Before the inspection we had been contacted by an advocate who were working with a family to help resolve some concerns they had.

Good

Is the service responsive?

Our findings

We spoke with people about how staff responded to their individual needs. One person told us about their health issues. They told us staff supported them to attend their health appointments. They told us when they got a letter from the hospital staff took time to go through the information with them and to remind them when their appointment was. They told us this stopped them worrying. Another person said 'they preferred to stay in their room but staff came in to check them periodically and have a chat' This helped them feel less isolated. We saw they were comfortable and had everything to hand, including cut up fruit and drinks. We observed staff entering their room and chatting with them.

We observed staff responding appropriately to people's needs through spending time with them and offering them appropriate choices. Staff were familiar with people's needs and conversed with people about their families and life events. On the day of inspection there was a staff member providing activities but we noted that all staff helped with day to day activities and demonstrated good team work. Relatives told us that the new staff were great and had formed good relationships with their relatives. One person unable to tell us verbally whether staff were kind to them put their thumbs up and nodded vigorously in agreement. This person's communication was severely restricted but their relative told us staff knew their needs and we saw staff trying very hard to establish what they wanted and acknowledging their distress at their inability to communicate verbally. Their care plan told us about this person's difficulties and how staff should try and address them which we observed staff doing in practice.

People's needs were assessed and kept under review. Changes to people's needs such as an infection which might increase risks to their overall well-being were documented in people's care plans. This meant that staff knew how to meet a change in people's needs. However care records were not all up to date and we found different information about meeting people's needs which meant that new staff would not be clear from the records which information was the most up to date.

.Designated staff provided structured activities throughout the day around people's individual hobbies and interests.

However on a Friday and the weekend there was no-one designated to provide activities. Staff told us weekends were busy with families visiting which gave staff more time to spend with people who did not have visitors.

Care plans started with a document called, 'How to support me.' This gave an account of how the person needed support and how they wished it to be provided. It took into account their routines and personal preferences. For some people this information was poorly developed and staff told us that some people were reluctant to give personal information. This was not recorded We found gaps in some of the newer staff's knowledge about people's life experiences or personal history. However new staff told us they were supported by more experienced staff on shift and there were always family members around to help answer their questions. We observed some staff that were particularly skilful in managing people's behaviour where they were resistant to care and they were able to demonstrate a good understanding of the people's behaviour.

We looked at the programme of activity which matched the needs and interests of some people but we found some people were unable to or unwilling to engage in group activity. The person providing the activities said they did provide some- one to one support with people and was assisted to do so with staff and another part time activities coordinator. Further thought could be given to the level and type of activities offered to people to ensure every person has some opportunity to engage.

We spoke with one person who was not able to retain information, however they told us they were okay and staff told us they had made good progress since being at the home and were now able to do more than they were doing at home and were regaining some of their independence and confidence back.

We saw staff listening to people and communicated appropriately to their needs. The manager had a complaints log and was able to demonstrate that she listened and responded appropriately to complaints which she and her staff learnt from. This meant that where care had not been satisfactory the persons concerns were acknowledged and where possible addressed. We had spoken to a number of people who told us that either they or a family member had raised concerns about their care and these had been addressed. The complaints procedure was visible around the home. Where concerns were

Good

Is the service responsive?

significant these were raised with the Local Authority and we saw evidence that the manager worked with the Local Authority and acted on any suggestions to improve the care being provided to people.

Requires Improvement

Is the service well-led?

Our findings

There were clear lines of accountability at the home and all the staff we spoke with felt the manager was knowledgeable and supportive. The manager was able to demonstrate how they supported and developed staff but relied on regular communication with staff whilst working with them on shift rather than more formal means of support. This meant there were limited records to show how the manager assessed and monitored staff performance and some staff had little concept of supervision. However we were assured this was being addressed by the appointment of an experienced deputy manager who could assume some of the responsibilities carried out by the manager almost immediately. This would help shape and improve the standards of care by correctly identifying where the shortfalls were.

There were systems in place to seek the views of people who used the service to establish if they were satisfied with their care or if improvements were required. Again we found an over reliance on informal systems where people were asked for their views. These were generally not recorded and therefore we were unable to see how the manager had responded to what people said. The manager told us that they had recently sent out satisfaction surveys to people using the service, their families and professionals but did not have the results to show us. The manager said this would inform them of how they were performing. Other means of engaging with people who used the service included meetings held at the home with people and chaired by staff. These were recorded to show what had been discussed and agreed. Care reviews which sometimes involved families. There were also visits from the provider which included some limited observational evidence, audit of records and what people said about the service. This audit was limited in scope in terms of people's voice as only a couple of people were asked their views so it was difficult to draw any conclusions from it or see how the audits evidenced good or poor practices.

There were systems in place to monitor the effectiveness and safety of the service and equipment used. However we did not feel these were sufficiently robust given the concerns we identified during the inspection particularly around infection control and the safe administration of medicines. Audits had been completed but then did not clearly state what actions were necessary to address any shortfalls, by whom and by which date, which meant the audits were not been used effectively. We also fund a lack of recording to demonstrate things were being done. For example the practice of shared slings to assist people with their manual handling needs. We were told these were washed regularly but there were no records to support this. We also noted that air mattresses designed to promote good skin integrity would only be effective if they had sufficient pressure. However there were no records in place when asked to show these were checked regularly. This meant we could not be assured the manager was effectively monitoring potential risk to people's health and safety or ensuring all equipment was fit for purpose.

The manager was engaged with a project run by other health and social care organisations to support them to reduce the risk of falls. The aim of the project was to support managers in identifying factors which could contribute to people falling. This could help the manager reduce risk through improved assessment of risk, early interventions and better record keeping to show if actions were effective or not. The long term aim of the project was to reduce the number of unnecessary hospital admissions. The manager was fully involved in the project which involved a considerable amount of work. We noted that since this involvement there had been a slight reduction in falls. However we found record keeping was poor and the analysis of falls did not always show us how the manager had interpreted the data and used the information to take actions to try to reduce the number of falls within the home. We acknowledged this was work in progress but found record keeping across the home requires improvement. It did however demonstrate that the manager was being proactive and responsive to people's needs and potential risks to their health and welfare were being managed and reduced.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control There were poor procedures in place to protect people from the risk of infection. Regulation 12.