TM & TR Ltd

Harewood 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

This inspection took place on 21 April 2015 and was unannounced.

Harewood House is registered to provide residential care for up to 29 older people. There is a passenger lift to assist people to the upper floors and the home is set close to Scarborough South Cliff and gardens.

The home had a registered manager in place. 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.

Visitors told us they thought their relatives were safe at the home. Risks to people were managed well without placing undue restrictions upon them. Staff were trained in safeguarding and understood how to recognise and report any abuse. Staffing levels were appropriate which meant people were supported with their care and to pursue interests of their choice. People received the right medicines at the right time and medicines were handled safely.

The home was not managed in a way to ensure that people were properly protected from the risks of cross infection. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

Staff were deployed in a way which ensured that people received the care they needed.

Visitors told us that staff understood their individual care needs. We found that people were supported by staff who were well trained. All staff received mandatory training in addition to specific training they may need. The home had effective links with specialists and professional advisors and we saw evidence that the home sought their advice and acted on this.

People's nutritional needs were met. Care plans contained information about nutritional and hydration needs, preferences were respected and risks well managed. Specialists were involved where necessary and risk assessments about nutrition and hydration were recorded and kept up to date.

The home was clear about its responsibilities around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were suitably trained and supported people to make informed decisions about their care.

The home had developed effective links with healthcare professionals and specialists were involved where necessary to ensure people had access to expert advice.

The environment was not well adapted to the needs of people living with a dementia and we have made a recommendation about this in the full version of the report.

Staff had developed positive relationships with people and were kind and caring in their approach. We observed that they responded to people's care needs and attended to them with kindness and empathy.

People were assisted to take part in daily occupations. Many people were living with an advanced dementia and the staff had adapted daily living activities to respond to individual needs.

People and those who acted on their behalf were encouraged to complain or raise concerns. The home supported them to do this and concerns were resolved with actions recorded.

The leadership promoted an open culture and people told us that the manager was approachable and responded to their comments. The manager was visible around the home and had a proactive approach. Communication at all levels was clear and staff understood their roles and responsibilities which helped the home to run smoothly. The provider understood the home's strengths, where improvements were needed and worked with stakeholders and others to improve the care for people living at the home.

Systems were in place to assess and monitor the quality of the service. However, we have made a recommendation in the full version of the report about ensuring that information gathered during auditing is used to improve the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were not protected because some areas of the home required attention to minimise the risks associated with the control of infection.

People had the opportunity to live their lives life without undue restriction because of the positive way risk was managed.

We observed that medicines were managed safely. However, the service did not regularly audit the way medicines were handled to ensure people were protected.

There were sufficient staff who were safely recruited and trained in how to safeguard people.

Requires improvement

Is the service effective?
The service was not consistently effective.

Staff were trained and supported to meet people's needs. The registered manager supported them to develop professionally.

People had access to healthcare and specialist services to meet their health needs.

The registered manager was fully aware of the principles of the Mental Capacity Act 2005 and how to make an application to request authorisation for a person's deprivation of liberty.

People were consulted about their meals, their nutritional needs were met and they had free access to food and drink.

The environment was not well adapted to the needs of people living with a dementia.

Requires improvement

Is the service caring?
The service was caring.

People told us that staff were caring. We observed that staff were kind and caring and that they understood people's needs well.

Staff consulted with people and treated them with respect.

Good

Is the service responsive?
The service was responsive to people's needs.

People received personalised care which had been discussed and planned with either them or a person who acted on their behalf.

Good

Summary of findings

Staff worked to ensure people's lives were as fulfilling as possible and they were responsive to people's care needs.

People's views were listened to and acted upon by staff

Is the service well-led?

The service was usually well led.

People told us the manager was supportive and visible around the home.

The culture was supportive of people who lived at the home and of staff. Lines of communication were clear. Staff understood their roles and responsibilities.

The registered manager had made statutory notifications to the Care Quality Commission where appropriate.

The quality of care was not always monitored effectively, for example, in the area of infection control. However, people usually had their needs met.

Staff were supported to improve their practice across a range of areas.

Requires improvement

Harewood 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 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 21 April 2015 and was unannounced; it was carried out by one adult social care inspector and an expert by experience. The expert by experience spoke with people and made observations. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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 speak to us directly about their care.

We reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

We did not request a Provider Information Return (PIR). The 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. However, we gathered the information we needed during our inspection visit.

On the day of the inspection we spoke with five people who lived at the home, three visitors and five members of staff including the manager. During the inspection we spoke with a health and social care professional and after the service we spoke with another health and social care professional about the service.

We looked at some areas of the home, including some bedrooms (with people's permission where this was possible) and communal areas. We looked at the recruitment, supervision and appraisal records of five members of staff, a full staff training matrix, rotas for the past two months, five care plans with associated documentation, a number of audits and policies and procedures.

Requires improvement

Is the service safe?

Our findings

The service was not safe.

Standards of cleanliness in the home were variable. When we walked around the premises we found that some areas of the home were clean and pleasant to be in. However, we saw that other areas of the premises were dirty and unhygienic. There was hard surface damage to furniture in the lounges and bedrooms which was an infection control risk. We noted that bannisters were damaged and laminate flooring was lifting in some areas. One person's room was particularly in need of attention, with a strong odour of bodily waste and faecal staining to bed linen and furniture.

We also observed that there was an insufficient system in place for keeping dirty and clean laundry separate. The floor of the laundry was dirty with gaps in the floor covering which was an infection control risk. The room was cluttered with objects unrelated to laundry and staff coats were also kept in this room. A store cupboard in the laundry room was used to store staff shoes. Storing personal items alongside laundry was an infection control risk. Mops were also stored in this cupboard, with heads down rather than up which would have aided drying. This created an infection control risk. There was a risk that clean laundry would become contaminated by dirty laundry. The conditions were cramped and there were no separate designated areas for clean and dirty laundry to ensure they did not come into contact with each other. This meant the home did not have an effective plan to keep the laundry room clean and hygienic and to minimise the risk of cross infection.

When we visited people's rooms, with their permission where possible, we noted that some en suite rooms did not have toilet paper in the bathroom, the cupboard under a wash hand basin had a detached door which was propped in place causing a trip hazard. In a shower room the skirting panel was missing, exposing bare wall and piping and the floor covering around the toilet was badly stained. In one en suite toilet, there was no lid on the cistern. In the bathroom with the bath hoist, the chair of the hoist was dirty. These were infection control risks.

We found that the registered person had not protected people against the risk of cross infection. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. .

Though we noted that there were no hand sanitisers available throughout the home, the manager explained that this was because they were a risk to certain people who lived at the home because they tampered with them and were at risk of ingesting the contents. As an alternative, staff carried personal hand sanitising gels with them. Staff confirmed they made a point of hand washing between visits to each person for personal care and understood the importance of adhering to infection control policies.

People using the service were not able to speak with us about their experiences. People appeared relaxed in the service but their comments did not relate to this key question. One visitor told us, "They are safe here. The staff are always on hand to calm any situation down."

The service had policies and procedures for safeguarding vulnerable adults which were available and accessible to all members of staff. Staff told us they would refer any concerns to a senior member of staff and knew that they would also need to contact North Yorkshire County Council which is the lead agency for the safeguarding of vulnerable adults in the area. This meant staff had the necessary knowledge and information to make sure people were protected from abuse. The manager had recently dealt with a safeguarding incident which provided evidence that they understood the process required and had acted appropriately and swiftly to ensure people were protected.

Staff told us they had received safeguarding training and training records confirmed this.

We saw written evidence that the manager had notified the local authority and CQC of safeguarding incidents where necessary and had cooperated in investigations.

We looked at four care plans and saw individual risk assessments had been carried out for each person. The risk assessments we saw included behaviour which may challenge others and areas of personal care. Risk assessments included instructions for staff on how to minimise risk and guidelines on how to ensure people did not have their liberty unnecessarily restricted. Staff told us

Requires improvement

Is the service safe?

they understood how to protect people through following the risk assessments. They were clear, for example on how to approach people who may be distressed to calm them, protect them and those around them.

The home was not purpose built for people who were living with a dementia related illness. The corridors were not well lit in some places, which caused a hazard to people moving around the home.

We examined staffing rotas and spoke with the manager about staffing levels. There were four members of staff on duty each morning. Staffing was made up of the manager or deputy, a senior carer who was also team leader, and two carers with ancillary staff. Three staff were on duty each afternoon, including the manager, a senior and a care worker. At weekends when the manager was off duty, there were two senior care staff and two care staff on duty. There were always two waking care staff on duty at night, including a senior carer. This was to care for up to a maximum of twenty nine people, though the manager explained that they would never admit more than twenty eight. During our visit there appeared to be sufficient staff on duty to ensure people were cared for safely. However, a visitor commented that "It would be better if there was one more member of staff on duty both during the day and at night."

Staff application forms recorded the applicant's employment history, the names of two employment referees and any relevant training. We saw that a Disclosure and Barring Service (DBS) check had been obtained prior to beginning work at the home and that employment references had also been received. This minimised the risk that people who were unsuitable to work with vulnerable people were employed.

The home had a policy on whistle blowing. Staff told us that they understood the whistle blowing procedure and were confident to raise any whistle blowing concerns. We noted that the whistle blowing procedure had been used recently and that the staff who had used it had been protected during the process.

We looked at the arrangements in place for the administration, storage, ordering and disposal of medicines and found these were safe. Medicines were stored securely in a locked medication room. We checked the medicines for three people and found that the number of medicines stored tallied with the number recorded on the Medication Administration Records (MAR). Medicines which were not in the monitored dosage system and were kept in packets were dated on opening and a running total was recorded. This ensured that staff would know when medicines became out of date and needed to be re-ordered. Creams were for individual's use, were dated on opening and recorded on a separate administration record. There were suitable storage arrangements for controlled drugs. A register was kept as required, and this was signed and checked by two members of staff at the time controlled drugs were administered. No refrigerated medicines were prescribed and there was no separate fridge available. The manager told us that they were sourcing a small dedicated fridge for this purpose.

Staff training records showed that staff had received up to date medicines training. A list of all staff who had training and were authorised to administer medicines was available.

Requires improvement

Is the service effective?

Our findings

The service was not consistently effective.

People told us that the food was “alright” or “good”. One person said “The food's ok.” This person added, “I can have a snack if I want one, I just ask and they'll bring a cuppa or a biscuit or cake.” A visitor told us, “The staff are good at calming people down when they get upset and they are really good at spending time talking with them.”

We noted that the corridors and rooms were decorated with pictures. However, these were not always suitable for people who were living with a dementia. Pictures did not offer an opportunity for conversation or engagement and there was little representation of places or events which may stimulate memory.

The environment was not well adapted to the needs of people living with a dementia. The home was not purpose built and there were a number of stairways and corridors with landings on different levels which people with cognitive impairment may find difficult to navigate. Some carpets were of a swirling patterned design which research has shown can cause distress and confusion to some people living with a dementia. There were few signs to assist people with orientation, no photographs or names on bedroom doors to assist people to recognise their rooms, and no pictorial prompts for important rooms such as toilets. We did see that staff had written the date and season on a blackboard in a dining area and we heard staff speaking to people about the weather and what was going on outside.

Although the environment lacked the openness which would support people to walk about the home unimpeded we noticed that staff took time to walk with people around the ground floor lounges.

We looked at staff induction and training records. Induction followed required topics and there was an induction specific to the home, its values and philosophy of care. Staff told us that they had received induction before they began their mandatory training. During this time they developed an understanding of each individual’s care needs and the philosophy of the home. Staff understood about people’s clinical needs. For example, one member of staff told us that they regularly looked at people’s care plans, and that the manager encouraged them to refer any concerns to senior staff so that health care professionals could be contacted.

Staff told us that new employees spent time shadowing a more experienced member of staff before they were permitted to work alone. This was to make sure they understood people’s individual needs and how risks were managed.

In addition to mandatory training, staff received specially sourced training in areas of care that were specific to the needs of people at the home. For example, staff had received training in dementia care. Most staff told us they had achieved or were working towards the National Vocational Qualification (NVQ) at level 3.

Staff told us that they received regular supervision and appraisals which the manager referred to as ‘job chats’ and we saw evidence of this in the staff records we reviewed. Staff told us this supported them to develop professionally and gave them support to give the care people needed.

The home had links with specialists, for example in diabetes care, Parkinson’s disease care, nutrition, sight and hearing, pressure care, continence care, mental health and the speech and language therapy team (SALT). This helped them to offer appropriate and individualised care. We saw that referrals for specialist input had been made promptly.

The manager told us they had good links with local GPs and district nurses. We spoke with a health and social care professional during the inspection who had regular contact with the home. They told us,

“If I have a person with complex needs who needs a placement, I am confident that Harewood House will assess their care needs well and that the staff will have the skills to manage people so that they have the care they need.”

The manager told us they used feedback from GPs and other professionals to help them give the best care they could and staff confirmed that they actively sought external professional’s advice. Records confirmed what they told us. For example we saw advice from a community mental health nurse and a tissue viability nurse which had been written into care plans to ensure people’s mental health needs, and needs associated with pressure care were met.

Requires improvement

Is the service effective?

Care plans included information about people's needs and preferences about their meals and drinks. We saw that those people who needed to be regularly weighed had these records in place, with actions recorded if changes in weight became significant. We also saw risk assessments around people's relationship with food and eating to encourage a moderate and well balanced diet.

We observed a lunch time across the three dining areas. People who needed support with eating sat in one dining room, and there was a member of staff at each of the tables assisting people with their meals. Some people had plate guards and some had pureed food. One person had a thickened diet but ate independently, though staff were watching throughout in case of choking. Lunch was well presented and looked and smelled good. When we spoke with staff it was clear that they understood the assistance individual people required with their eating and drinking. Care plans contained information about people's preferences and needs relating to eating and drinking and associated risks. We saw that equipment to assist people was in place and specialist diets, finger foods, or softened diets were available when required. Referrals to the dietician and speech and language therapist were recorded when people needed this with advice incorporated into care plans.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that any decisions are made in people's best interests. The manager told us that a number of applications had been made to the local authority for DoLS to be put in place, and that a number of assessments had taken place. There had been a number of DoLS authorisations as a result of specialist assessments and we saw these on individual files. The registered manager had not however notified CQC as they should about these authorisations.

People's mental capacity was assessed to ensure that they had the support they needed to make decisions about their care. The manager explained that Best Interests decisions were made in line with best practice We spoke with a health and social care professional who confirmed that Best Interests decisions were carried out in line with current legislation to protect people. Independent Mental Capacity Advocates were used when people were assessed to have impaired mental capacity and required support with decision making.

When we looked at training records and saw staff had received up to date training on DoLS and the Mental Capacity Act (2005). Care staff were clear about the process for DoLS and mental capacity assessments as well as Best Interests decision making and the implications of lasting power of attorney powers. The manager understood the implications of the recent Supreme Court ruling which had clarified the notion of deprivation of liberty for people in a care home setting. This meant that people could be protected regarding their mental capacity.

We observed that staff routinely asked for people's consent before giving assistance and that they waited for a response. When people declined, staff were respectful and returned to try again later if necessary. Staff told us that they understood the importance of taking people's mental capacity into consideration when offering care and spoke about assuming that people had capacity and ensuring that people were consulted at a time which was best for them.

Care records showed that people's consent to care and treatment was sought. Staff recorded how they looked for consent when people were not able to give this verbally, for example, through observing body language or facial expressions. Discussions with people's chosen representatives were also recorded. This meant that the home ensured people were consulted about their care.

We recommend that the registered manager consults best practice guidance on adapting the environment to the needs of people who are living with a dementia.

Good

Is the service caring?

Our findings

The service was caring.

People told us that they were cared for in a kind and caring way. One visitor told us,

"The staff here are really lovely with people, (the manager) is very kind and the staff are all the same."

Relatives and other visitors told us that they were encouraged to visit at any time and that they were always made to feel welcome.

The manager told us that staff concentrated upon giving people choices, so that they were as in control of their lives as possible. We saw that staff did give people choices. Staff told us that they understood that it was important to support people to feel as independent as possible. They stressed the importance of giving people time to make choices and to take considered risks.

We observed that staff spoke with people in a kind and respectful manner and clearly knew them as individuals. Staff responded to them with warmth and understanding, taking time to listen and understand the emotional content of what they were saying. They engaged with people in a positive way, which clearly contributed to their wellbeing. Staff spoke with people who were distressed or angry in a way which was respectful and diminished their anxiety. On one occasion we observed a member of staff recognising that a person may be in pain, speaking to them with empathy.

We observed that staff regularly consulted with people about what they preferred to do, whether they were comfortable or needed anything. People responded to staff in a positive way and we saw people smiling and looking relaxed.

A social care professional told us,

"The manager and staff here are brilliant, they are caring and kind, and are particularly good when people are distressed."

Staff explained people's personal histories, their likes, dislikes, health histories, family circumstances and important relationships. They told us this helped them to give care which was appropriate to each individual. They told us about the importance of treating people with regard for their privacy and the need to maintain respectful relationships with people to preserve their dignity.

Staff told us that when a person reached the last days of life, staff spent time in their rooms to reassure them and provide comfort. The manager told us that they consulted with each person's family about last wishes and funeral arrangements when this became necessary. They told us that the home was well supported by the District Nursing service. Pain relief, end of life care and necessary equipment were arranged in consultation with them. We saw a number of Do Not Attempt Resuscitation authorisations on file which were correctly completed and consulted upon.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs.

One visitor told us, "The staff help people when they need it, but they give them time to do things for themselves too." Another person told us, "I'm lonely. I get fed up because there's nowt to do". We spoke with other people who lived at the home but their comments did not relate to this key question.

The manager and staff told us that they had a meeting each morning where they discussed the changing needs of each person who lived at the home. Changes in care needs were documented so that the service could respond consistently. The manager told us about some changes which had been made to the organisation of the tea time dining experience, with a reduced number of people being assisted in a small dining room so that staff could focus their attention on people who were more vulnerable.

Staff told us that they worked together to ensure the care plans met people's needs. Staff told us that they took time to ensure people's control over their lives was maximised, for example, by breaking tasks down into sections so that people could engage with each step. One person may be able to pick out clothing they preferred to wear, but would need help with dressing. Another person may be able to stand if they were encouraged to move to the front of their seat before attempting to rise.

Care plans were agreed with people where possible or with those acting on their behalf. If this was not possible, the manager told us that they talked through care plans with people when they had the capacity to understand. Plans contained details of how people preferred to receive their care. Most plans contained personal histories and information which would allow staff to offer care focused on each individual.

We saw that written plans were regularly reviewed by care staff to meet people's changing needs.

The manager and staff described an approach which was focused on the individual. We noted that the interactions between staff and people living at the home were frequent with much positive reinforcement. We observed staff validating people's feelings and providing meaningful engagement. For example, a member of staff discussed a person's cold feet in a caring and responsive way, we also observed a member of staff talking sensitively with a person about an absent family member they were searching for. Staff spoke with people in a friendly, open and inclusive way.

We observed staff playing a bean bag game with people who were enjoying the interaction and sense of achievement. The manager told us that one person regularly went out alone, with an assessment in place to minimise the risk involved. We spoke with this person who confirmed that they often went out into town but that they told staff when they would be back.

We did not see rummage boxes of interesting items which research has shown is stimulating for people living with a dementia related condition, however, the manager told us that this had been piloted without a positive effect. The manager also told us that interesting items in communal areas became a choking risk to certain people due to their dementia. Other people destroyed items as part of their response to the environment which posed a risk to themselves and others. We did see that some people carried such items as soft toys, fabric handkerchiefs and handbags with them which they found comforting. We noted that a large proportion of the people living at Harewood House were living with an advanced stage of dementia and that stimulation was more effective when planned on an individual basis. This focused upon talking, looking at magazines and pictures, positive physical contact and emotional engagement.

People appeared well dressed and with attention to detail, for example with nails and hair well attended to. People wore clothing suitable for the season and appeared warm and comfortable.

The staff and people we spoke with told us that the home encouraged visitors, and that staff supported people to maintain their relationships. During the day of our inspection we noticed that there were a number of visitors who were warmly welcomed by staff.

Visitors told us they were encouraged to express any concerns or complaints they might have and one visitor told us of times when they had discussed some area of concern to have it resolved. The manager told us that complaints were investigated by them with outcomes recorded. We saw written evidence that this was the case. The manager told us that any concerns were usually dealt with immediately and there had been no formal

Good

Is the service responsive?

complaints made by people living at the service or those acting on their behalf since the last inspection. Concerns and complaints made by staff were treated seriously and we saw evidence that a recent concern had been dealt with correctly and the outcome recorded.

Requires improvement

Is the service well-led?

Our findings

The service was usually well led.

The visitors we spoke with confirmed that efforts were made to hear and act on their views. They told us that staff listened to people and acted on their wishes. Lines of communication between people, staff and management were open and supportive. We observed that the manager was visible throughout the day of inspection and that people and staff were relaxed around them. This meant that people received good care given by a well led team of staff.

We spoke with a visiting health and social care professional who told us that the manager involved them in regular reviews of care, requested advice and put advice into practice. They also told us,

"The manager here is really on the ball. Their communication skills are excellent, they keep in touch with families and understand every nuance of each person's care."

Staff told us that the manager was approachable and supportive, that they listened to them and took their comments on board. Staff told us that the manager gathered their views and those suggestions were appreciated and encouraged. They received support to develop professionally and to pursue training which would assist them in their role.

In discussion with the manager it was clear that they understood the key challenges and risks involved in running a responsive and effective service for the people who lived at the home. For example, they highlighted the difficulties around providing stimulation and retaining skills for people who were living with an advanced dementia. They recognised the difficulties around detecting health issues in people who were not in a position to speak for themselves and the importance of working in partnership with specialists and other professionals. They stressed the importance of not becoming complacent and of constantly looking for ways to improve each individual's experience and wellbeing.

Staff understood the scope and limits of their role and responsibilities which they told us helped the home to run smoothly. They knew who to go to for support and when to refer to the manager. The manager and staff reflected the culture, values and ethos of the home, which placed the people at the heart of care.

Communication with relatives and other interested parties was promoted through informal meetings and one to one discussions about each individual. We saw records of recent staff meetings where individual care plans, staff training needs and good practice issues had been discussed.

Notifications had been sent to the Care Quality Commission by the service as required. The manager had recently handled a whistleblowing incident effectively and according to procedure which had minimised disruption to the people living at the home and to the existing staff group.

The manager carried out some audits on areas of quality and safety within the home and we sampled the results of environmental audits and a range of safety tests for example, emergency lighting, lift servicing, fire checks and water temperatures. Medicine stocks and recording were checked each month on receipt from the pharmacy, though audits were not written down. Care plans were updated and checked each month. However, we found that auditing had not always been effective. For example, some infection control issues were not recognised through audit and were therefore not addressed. The manager told us that the results of audits were discussed in meetings and all staff were made aware so that any shortfalls were addressed to improve the overall quality of the service.

We recommend that the manager consults best practice advice to ensure that the home operates an effective quality assurance system, to improve the care people receive and the environment they live in.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people against the risk of cross infection. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.