Barbara (Aylesbury) Ltd

Lakeside Care Centre

Inspection report

Brambling
Aylesbury
Buckinghamshire
HP19 0WH
Tel: 01296 393166
Website: www.lakesideatwatermeadcarehome.co.uk

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Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This was an unannounced inspection during which we found the care home provider required improvements in the following areas: assessing and managing risks related to infection control and cleanliness; obtaining consent from people and how the quality of the service was managed. You can see what action we told the provider to take at the back of the full version of the report.

Lakeside Care Centre is registered to provide residential and nursing care, for up to 59 older people. The service also provides respite care for people who need support on a short term basis. At the time of our inspection 48 people were living in the home. The service is managed by a registered manager. A registered manager is a person

Summary of findings

who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We observed the communal areas and people's bedrooms were clean and comfortable. We identified concerns about the hygiene standards in the kitchen. Food was not stored correctly and safely and the environment required cleaning. The cleaning schedule was not accurate and did not match with what we saw. An audit of the health and safety standards in the kitchen had not identified these concerns.

Care plans and risk assessments were in place for each person. People's health needs were monitored and staff worked well with other professionals such as GP's to ensure their needs were met.

People told us they were pleased with the care they received, these views were shared by people's relatives. We saw staff were kind and caring towards people and treated them with respect. We saw staff responded to people's needs quickly and in a caring way. The call bell records showed staff responded quickly to people's requests for assistance.

People told us they liked the food in the home, and there was plenty of food and drink available to them at all times. People's cultural and dietary needs were respected. A wide range of activities were available to people.

Staff received training, supervision and appraisals. We spoke with staff about the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The MCA is a law about making decisions and what to do when people cannot make some decisions for themselves. The Deprivation of Liberty Safeguards (DoLS) are part of the Act. They aim to make sure that people in care homes, are looked after in a way that does not inappropriately restrict or deprive them of their freedom. Some staff demonstrated minimal understanding of capacity and consent, and acting in people's best interests. The registered manager told us the majority of staff had not received training in this area, but training for all staff was planned for in the coming weeks.

People's care plans included assessments of people's capacity to make decisions and choices. However, the documentation was not in line with the MCA code of practice. It was unclear which decision the person was making and if they had the capacity to make it.

There were no records to show the provider regularly requested feedback from staff or people or their representatives on how the service could improve.

We found a number of breaches 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

Some aspects of the service were not safe. The majority of staff had not received training in the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). Not all staff could describe how the legislation applied to their role and the rights of people they cared for in respect of the act. Completed mental capacity assessments did not show what decision the person was being expected to make.

We found poor and unsafe standards of hygiene in the food preparation and storage areas of the kitchen. Food was prepared in an environment which was unclean. Food was not safely stored or labelled in containers and use by dates were not always recorded or adhered to.

People told us they were happy living in the home and they felt safe. We saw risk assessments and care plans were up to date. Staff had received training in how to safeguard people from abuse and were clear about how to respond to allegations of abuse.

Is the service effective?

Good

The service was effective. People told us they were consulted about their care and were able to make choices about how and when their care was delivered. We saw people were supported to maintain good health and access health care services when required. Care plans and risk assessments were written clearly. A training programme for staff was underway, ensuring all staff had completed the training deemed mandatory by the provider.

People were provided with diets to meet their health and cultural needs. They were given choices about the food they ate, and told us food and drinks were always available.

The home was spacious and well decorated. Outdated en suite rooms were being renovated so people's needs could be appropriately met. People were able to personalise their bedrooms to make them feel at home.

Is the service caring?

Good

The service was caring. People told us the staff were caring and they were given choice over aspects of their care. We observed how staff interacted with people in a positive and person centred way. People were able to maintain relationships with those lived in the home and outside of the service.

We observed how staff protected people's dignity and privacy when providing personal care for people, and used discretion when speaking to people about personal topics. Staff were able to explain how they cared for people in a person centred way, and were proud of the service they delivered. They were familiar with people's needs and cared about the people who lived in the home.

Summary of findings

End of life care was an area being developed by the service to ensure people's rights and dignity were maintained at the end of their lives.

Is the service responsive?

Good

The service was responsive. People who used the service, and where appropriate their relatives or representatives, had been involved in the care planning process. Their care was reviewed monthly with them.

Staff responded to people's needs quickly and in a caring manner. Call bell records showed staff reacted to people's alerts for help on average within two to four minutes.

People told us the staff were responsive and friendly. They valued that staff had time to talk with them as well as carrying out the practical tasks of caring.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. At the time of the inspection no quality assurance feedback was available. All feedback from people was given to the manager verbally. This meant they were not able to accurately assess the quality of the service and drive forward improvements based on their findings.

A range of audits of the service had been completed. These were to ensure different aspects of the service were meeting the required standards and the service was safe. However, we found one audit had not identified the deterioration in hygiene standards in the kitchen. Omissions in recordings of care had not been identified in another audit.

The home had a registered manager who had relevant experience, skills and knowledge. During our dealing with them they were honest about the challenges of the service. They spoke openly and listened to our feedback. They were accessible to the staff, who told us they felt confident going to the manager or senior staff for advice or guidance. People were happy with the service on offer and how staff and management interacted with them.

Lakeside Care Centre

Detailed findings

Background to this inspection

The home had previously been inspected on 15 August 2013 when it was found to be meeting the requirements of the law in the areas inspected. These included care and welfare of people who used services, staffing and supporting staff.

We visited the home on 7 and 8 July 2014. The inspection team included a lead inspector, specialist advisor in social care and an expert by experience. This team had expertise in supporting and advocating on behalf of people with physical needs, older people and people with dementia.

Before the inspection we reviewed all the information we held about the home, this included the information the provider had sent us and information other people had shared with us. The Care Quality Commission asks all providers to complete and send us a Provider Information Form (PIR). The PIR is a form that asks the provider to give some key information about its service, how it is meeting the five questions, and what improvements they plan to make. We used this information to plan our inspection.

We met with people throughout the home and saw how care was provided to people during the day. We were able to observe and speak to people during lunchtime. We spoke to nine people who lived in the home and five relatives. We interviewed the home manager and seven staff including senior staff, the chef, domestic staff and health care assistants. We looked at five people's care records and documentation in relation to staff recruitment and training, risk assessments, quality assurance audits, policies and procedures.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

When we went into the kitchen we found the area was not clean. For example, work surfaces and floor areas were dirty. Food was not stored in a way that was hygienic or safe. Some food was not covered or appropriately labelled, and two items of food had passed their use by date.

The kitchen cleaning schedule showed that some areas had not been cleaned as required by the schedule. For example the walls of the kitchen had only been cleaned three times in the last four months instead of weekly. Some areas of the kitchen, according to the schedule, should have been cleaned daily. Our findings showed that this type of cleaning had not taken place. This included basins, work surfaces, taps and floors. We shared our findings with the local authority Environmental Health Department.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who lived in the home and their relatives told us they were happy with the care they or their family member received. They told us they felt safe living in the home. People were involved in the planning of their care and felt their choices had been respected. We noted appropriate risk assessments had been completed for each person. There were suitable plans in place to manage risks to individuals safety for example falls, moving and handling and pressure sores.

People said they had the freedom to make choices and decisions about how their time was spent each day and how their care was delivered. The Mental Capacity Act 2005 (MCA) is a law about making decisions and what to do when people cannot make some decisions for themselves. The Deprivation of Liberty Safeguards (DoLS) are part of the Act. They aim to make sure that people in care homes, are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

Staff told us they had not received training in MCA or DoLS. This training was, according to the home's policy, mandatory for all staff. Only four staff of the 55 had received this training. Staff did not demonstrate a good understanding of these issues.

We read in one person's care plan they were receiving their medicine covertly. This meant their medicine was hidden in their food because otherwise they would not take it. Staff considered that these medicines were important and the person must have them. However, the care plan section regarding their mental capacity to make this decision had not been fully completed. Whilst we could see the staff were acting in the person's best interest the documentation was not in line with the MCA code of practice. The best interest process had been partially followed with records showing discussions had taken place with the appropriate physician. It was not clear the persons spouse had been consulted.

The provider's policy on the Deprivation of Liberty Procedure stated "It is vital that the service user's capacity to make informed decisions is assessed and documented in their plan of care." This meant the person's right to choose whether to take their medication had been denied, as the medication was being administered covertly.

Only two senior staff had some understanding of how the Act applied to their role and the human rights of the people living in the home. The manager told us MCA and DoLS training was planned to be carried out with all staff in the following two weeks.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home had a copy of the local authority's procedure for responding to safeguarding concerns. This was prominently displayed so that staff could see it. The manager was able to explain to us how they would respond to allegations of abuse and this was in line with the local authority agreement on safeguarding vulnerable adults. In addition, we saw evidence that the registered manager had notified the local authority, and us, of a safeguarding incident. The majority of staff had received training in safeguarding. Staff were confident about how to recognise and report concerns of abuse.

We looked at five staff files and saw the home operated a robust recruitment procedure. Files contained photographic identification, evidence of disclosure and barring service (DBS) checks, references including one from previous employers and application forms. We saw from the records supervision took place every two months to make sure staff received support and to improve the quality of the service. For example discussions had taken

Requires Improvement

Is the service safe?

place about specialist training staff needed, and how their skills could be improved. The nursing and midwifery council register was checked every year to make sure the nurses were still registered to practice and safe to practice.

Sufficient staff were available to support people. The manager used an assessment tool to determine what staffing levels were needed according to people's needs. People said there were enough staff and call bells were answered quickly. The new call bell system allowed for handsets to be removed from the wall mountings in each room so they could be kept with the person. We checked the records which showed on average call bells were responded to within two to four minutes. We found this response time had been consistent over the preceding weekend. Staff had time to chat with people as well as provide the care they needed. Although staff were busy we did not see them rushing around the home and they paid attention to people's needs.

Risks were appropriately managed. We saw where risks were identified appropriate risk assessments were in place. For example, risks to people's tissue viability and to people's mobility. Risks were identified and measures put in place to reduce the risk. All risk assessments were reviewed monthly or as circumstances changed. The reviews were dated and signed by the reviewer. We saw that appropriate actions in relation to the evaluations had been taken.

Good

Is the service effective?

Our findings

People told us they were happy with the way the service was delivered and how the staff cared for them. They felt their needs were being met by staff.

The provider told us 37 people had a physical disability, the majority of whom had mobility difficulties. We saw each person had a mobility care plan and a moving and handling risk assessment in place. Staff were familiar with these. We observed how staff assisted people to mobilise in a safe way and according to their care plan.

A programme of refurbishment and adaptation of en suite rooms was underway. Some people had baths in their en suite that they were unable to use due to mobility problems. Wet rooms were being provided to ensure people's bathing needs were met. The home also had shared bathrooms, which had recently been refurbished with new baths, showers and bath chairs. This meant people could choose to have a bath or shower in an environment that met their needs.

The provider had completed assessments on people's risk of malnutrition and dehydration. This was to ensure their health was maintained. We read how people's nutrition and dietary needs had been assessed and reviewed regularly. People told us they enjoyed their meals and had plenty of choice and alternatives were available if requested. Supplementary drinks and food were offered mid-morning, afternoon and evening in between meals. Comments from people included "The cook makes wonderful cakes but I have to be very careful with my weight" and "The food is very good".

We observed lunch being served in the dining room. People had chosen from the menu the previous day and meals were attractively presented. The food looked appetising and appealing. Where necessary staff checked frequently that people were managing to eat their food and offered appropriate support when needed. Additional drinks were offered during the meal and people had a choice of desserts. One person who required assistance was provided with discreet and sensitive support.

One person had specific dietary needs. Staff had good information about what these needs were, and about the person's preferences. This information was available in a number of areas so that staff had easy access to it.

Residents meetings were held every couple of months. Records showed the manager had responded to requests people had made during these meetings. People gave feedback about aspects of the running of the home and the activities they preferred, and the manager took action in relation to these comments. For example, they had requested menus were placed on the dining room tables, and a request for sausage sandwiches to be made available.

People and their relatives told us they were happy with the way staff cared for and supported them. One person told us: "I have been in several homes and I found this the best for me. They have a key worker linked to each resident so we can build up a relationship, they are all very compassionate." A key worker is a member of staff who works with a person, keeps up to date with their needs and helps to coordinate their care. This person also told us they and their social worker had been involved in developing their care plan and the staff responded to all their needs. The person told us they had specific health problems and they felt the staff had always responded well when needed.

Care plans were presented in an easy to follow format and included information related to the health, social and mental health needs of each person. Each file was broken down into separate sections enabling staff to find the information they needed.

Some people had completed a "This is me leaflet", which recorded aspects about them that were important to them, and that others might find useful to know. This was optional and not everyone wished to complete it. It detailed amongst other things their preferred name, how they relaxed, their mobility, sleep patterns and eating and drinking preferences. Where people were not able to communicate their preferences verbally it was important that this information was written down. The aim was for this information to be shared with other organisations, for example if the person was admitted to hospital.

People's psychological needs were taken into account by the provider. Referrals to the mental health team were evident in care plans, and reassessments of people's needs took place where concerns had been raised about their mental health.

Although we found some gaps in people's records we also found good practice. One nurse had written to the GP to

Good

Is the service effective?

give feedback on different treatments that had been prescribed to a person. They observed some treatments were more successful than others and requested a repeat of the most successful treatment.

Most areas of the home were clean and tidy, apart from the kitchen. Where work was needed to update the décor or furnishings, this was underway. Each person's room was personalised to enable them to feel at home. We saw moving and handling equipment was readily available on each floor to ensure people did not have to wait for equipment before their needs could be met.

Staff told us they received induction training and on-going support from senior staff through supervision and appraisal. Records verified this. They understood the concept of person centred care and how they applied this to their role. Some staff had attended additional training outside of the mandatory training in areas such as end of life care and oral health.

Good

Is the service caring?

Our findings

People told us staff treated them compassionately and with kindness. They had time for a chat and pleasantries with people as well as attending to their needs. Staff were aware of people's needs and responded quickly when their needs changed. One person said "They are all very good, I have no complaints at all." A relative said "(my relative) has settled in very well. It was her choice to come here and it is lovely because everyone is so friendly and we can easily take her around the lake or for lunch at the local pub". Another relative told us "Whenever I come in he is always nice and clean and shaved. I don't have any problems."

We observed positive interactions between staff and people, and between staff and relatives. Staff were respectful, for example they addressed people by their preferred names. Staff respected people's privacy by knocking on people's doors before entering. We noted personal care was carried out in people's bedrooms or bathroom with the door closed to ensure people's privacy and dignity was maintained. We observed how the bathroom door opened out into the main corridor. The provider had placed a privacy curtain behind the door to ensure people's dignity was maintained if staff had to leave or enter the bathroom whilst they were using it. We saw discreet interactions between staff and people during lunch and in the corridors, where staff spoke quietly to protect people's privacy.

When discussing with staff how they cared for people, we found they were well informed about preserving people's privacy and dignity and treating people with respect. Staff felt the home provided good quality care. One staff member told us when carrying out care "You just need to take your time." Another staff member told us "I have booked my bed here."

One person described the home as "It's lovely here, all the staff are very friendly and always talk to us." Another person who had been in staying in the home for respite care told us they had a nice room and could choose the times their care was delivered. Another person confirmed this, they told us they could choose what time they got up each morning and what time they went to bed. They said this choice was on offer to everyone, they were aware other people went to bed much later than they did. During our inspection we observed a number of visitors entering and leaving the building.

We saw staff were sat with people outside on the veranda overlooking the lake and chatting. There was a very relaxed atmosphere in the home. We saw how people were greeted with a smile from staff and an offer of help if required.

A senior member of staff was able to describe how they and the staff team cared for people by ensuring people were asked their opinion and given choices. Staff asked people what they needed or wanted before they acted. This ensured people were listened to and their care was appropriate to their needs.

Most people had an end of life care plan. This was a record of how people wished to be cared for at the end of their life, for example, if they wished to go into hospital or stay in the home. Where people did not wish to discuss their end of life care but were happy for their relatives to, they were consulted. This meant staff would be aware of people's preferences regarding how they wished to be cared for at the end of their life and they would respect their choices.

Some nursing staff had attended end of life training, this was run by the local hospice. This enabled them to facilitate people's wishes and to know how to provide the specialist care that people may require at the end of their life. Additional training for more staff was planned.

Good

Is the service responsive?

Our findings

People who used the service, and where appropriate their relatives or representatives, had been involved in the care planning process. People's needs had been assessed and care plans were in place. People received care, and support when they needed it .Care files showed how professionals worked together for the benefit of people who use the service. For example, GPs, a tissue viability nurse and advocates attended the home to see people. The home also had a hairdressing salon and a visiting chiropodist. We were told by one person they had their own chiropodist who visited the home and they were not under any pressure to change. They were given choices and control over who provided the treatment and their health needs were monitored by specially trained and qualified people.

Care plans showed people discussed their care needs with staff monthly. Where they were unable to do so their relatives were encouraged to review the care provided. Any changes required were actioned, for example one person had been referred to a specialist wound care team to treat skin ulcers. Care plans were written in a personalised way including people's personal preferences. One person preferred to have a shower every other day, another person's preferred drink was cranberry juice. People's needs were discussed daily within the staff team during handover which took place three times a day.

We observed how staff spoke with people in a reassuring and supportive way to reduce their anxiety. They understood how the normal routine of the home could negatively impact upon people. They had made arrangements to minimise this. For example, during practice fire alarms they did not evacuate people from the home. When people were ill or at the end of their life, domestic activities in or close to their room which could be disruptive were stopped or minimised.

A relative told us how a person was settling into the home, they said "She is just getting used to the activities now and they do try to tailor them to residents' interests". There was an extensive weekly programme of activities published on the notice board and a leaflet delivered to people's rooms. A range of activities were available to suit people's level of mobility, and preferences. We observed several people had organised their own entertainment for example jigsaws, dominoes and a group were watching TV in the separate lounge area. There was also a monthly film choice for people and a library which held talking books. A pet as therapy (PAT) dog also visited the home. A non-denominational church service was included on the activity programme for those who chose to attend.

We saw a person returning from a stay in hospital. The manager had not received any notice of their return. The person's mobility needs had changed and they now required a wheelchair. No information had been sent to the home regarding the person's health needs. Staff were requested by the manager to contact the hospital immediately to ensure they were clear on how to support the person. This ensured the person received consistent care when they moved between services.

The provider had a complaints policy and procedure, which was displayed in the reception area. The home's complaints procedure was being printed in a new handbook for people and the plan was to place one in each person's room. We looked at the complaints log, which showed one complaint had been made since January 2014. We could see how the manager had responded to the complaint and an action plan had been put into place. We saw evidence the actions had been taken place to minimise the risk of a reoccurrence and keep the person and others safe. We noted nine compliments had been recorded for the same time period. One person told us "It's lovely here; all the staff are very friendly and always talk to us. I have no complaints." Another said "They are all very good, I have no complaints at all."

Requires Improvement

Is the service well-led?

Our findings

The manager told us they gained informal feedback from people when they spoke with them. The activity organiser feedback some comments people had made, but this was not regularly recorded and did not include everyone in the home. Records of compliments and complaints were available, however they did not have a system in place to record and analyse feedback, in order to drive forward improvements to the service. In addition there was not a process in place for stakeholders, for example visiting health care professionals to feedback their views of the quality of the service. The provider acknowledged the importance of this and had planned to send out questionnaires to people who use the service and visiting professionals.

The manager had completed a range of audits of the service. These were to ensure different aspects of the service were meeting the required standards. The audits covered a number of areas such as the laundry, care plans and the environment. However, we saw a recent health and safety audit carried out by the manager in June 2014 had included the kitchen but had not identified the hygiene of the kitchen as requiring attention. The care plan audit had not recognised omissions in records. For example staff records of person's behaviour had not been fully completed.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they thought the home was well run and they could speak freely to the manager. We saw people were comfortable talking to staff and the manager. We observed visitors and the manager engaging in a positive way.

Staff told us they felt supported by the senior staff and the manager had an "open door" policy. They told us the manager was encouraging and approachable. During the inspection we saw the interaction between the manager and staff. This appeared to be comfortable and relaxed. We saw the manager's office door was open apart from when confidential information was being discussed. We saw staff and relatives visiting the manager to talk with them.

Training, supervision and appraisal was provided to all staff regardless of their position. They were clear who they were line managed by and therefore supervised by. They were positive in their attitude to working in the home, presenting as staff who were proud of the service they offered. One staff told us "It's lovely here, I will be staying until I retire as I enjoy it." On the day of the inspection the director of the home was present. They dealt with and monitored the financial aspects of the service. The manager told us they received support and supervision from the director and guidance when needed.

The home had a positive culture of focussing on people as individuals and meeting their needs. Staff understood how people wanted their care delivering and the policies and procedures in place to support how they carried out their roles.

The manager and a member of staff told us they were being supported to offer training to other team members in an area of specialist knowledge. The manager's aim was to empower staff to share valuable insight and knowledge, to improve the team's skills and the quality of the service.

Staff meetings were held every three months, the manager told us the main purpose was to share information about people in the home, including any concerns raised by people. Staff also discussed any accidents or incidents that had occurred. Handover meetings took place three times each day to report and share information between staff.

Accidents and incidents were recorded and investigated. Action plans had been put into place where necessary to try to prevent accidents happening more than once. We saw that any learning from these events was shared to improve the service. For example one person's care plan and risk assessment had been updated and equipment had been bought to ensure the risk of harm was minimised. The manager told us they were intending to put together a spread sheet so that they could see if there were any emerging patterns. By doing this they could take preventative action to minimise the risk of accidents.

The registered manager's previous experience included nursing in the area of tissue viability. They were able to share their experience skills and knowledge with other staff. They told us they still encouraged staff to engage with the community tissue viability nurse. The manager wanted the best treatment available for people and as a result they would be kept up to date with new developments and guidance.

Links to the local community were maintained. The week prior to the inspection a fete had been held at the home

Requires Improvement

Is the service well-led?

which was open to the local community. People were going to decide how the money raised would be spent. Other community contacts included placements for student nurses from nearby universities. Work experience students from local colleges and pupils from the local schools. A neighbouring church provided services to people of the same faith. People from the home also visited community museums and theatre.

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
Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining the consent of people in relation to the care and treatment provided to them. Regulation 18.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person did not have suitable arrangements in place to maintain appropriate standards of cleanliness and hygiene of the premises. Regulation 12 (1) (a) (b) (c) (2) (a) (c) (i) (ii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have suitable arrangements in place to identify, assess and manage risks relating to the health, welfare and safety of service users and others. The registered person did not have suitable mechanism in place to regularly seek the views of people, persons acting on their behalf or persons who were employed to provide care with regard to improving the service provided** **Regulation 10 (1) (a) (b) (2) (e)**