Baselink Care Limited

Hillsdon Nursing Home

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**

Summary of findings

Overall summary

This comprehensive inspection took place on 2, 3 and 11 November. The first day was unannounced.

Hillsdon is a nursing home for up to 21 mainly older people and there were 19 people living there when we visited. Bedrooms are situated on the ground and first floors of the building. Most bedrooms are single bedrooms, but two are shared.

The home is run by its owners, one of whom is its registered manager. 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.

People were treated with kindness and respect and staff maintained their dignity. Their needs were assessed and kept under review. They received personalised care that met their individual needs and respected their preferences. Their health was monitored and referrals were made where necessary to doctors and other health and social care professionals. Medicines were managed safely.

The service had attained Gold Standards Framework accreditation, a nationally recognised standard, for the quality of its end of life care.

People spoke positively about the food. They received the support they needed to meet their nutrition and hydration needs.

Staff morale was good. They were well supported through training and supervision to meet people's needs. There were sufficient staff on duty to meet people's needs. However, many people were highly dependent, requiring two staff at a time for aspects of care such as moving and handling. Two people in the lounge often did not have staff present to support them, particularly in the morning. We have made a recommendation regarding the deployment of staff in communal areas.

There were shortfalls in the assessment and management of some risks, in particular the risks associated with using bed rails. Many people had bed rails raised when they were in bed, yet for the people whose records we viewed the risks of these had not been assessed, nor had consent been obtained or a best interests decision made in line with the requirements of the Mental Capacity Act 2005. Oxygen cylinders had not been stored safely. You can see what action we told the provider to take at the back of the full version of the report.

Whilst many areas of the premises were visibly clean, some areas were grubby with debris and cobwebs. Some paintwork and upholstery was not intact and so would be difficult to clean effectively. An appropriate standard of hygiene for a nursing home was not maintained in the laundry. The service had not undertaken its own infection control audits, relying instead on monitoring visits from the local authority and Clinical

Commissioning Group, who had advised the service of shortfalls. You can see what action we told the provider to take at the back of the full version of the report.

Suitable employment references were not obtained for some staff. The information required to be retained in respect of staff, such as a full employment history with a satisfactory written explanation of any gaps, had not been kept. You can see what action we told the provider to take at the back of the full version of the report.

Effective systems were not operating to monitor the quality of service being delivered and the running of the home and to bring about improvements that were needed. Shortfalls identified through external monitoring visits and risks highlighted in a 2014 fire risk assessment had not been addressed. The registered manager had limited time available to attend to management responsibilities because they were rostered to deliver care, covering for long-term staff sickness absence. The registered manager told us some documentation relating to quality assurance and premises safety was locked in the nominated individual's office. They did not have ready access to records they needed to meet their management responsibilities as manager. You can see what action we told the provider to take at the back of the full version of the report.

The registered manager and nominated individual had notified CQC about most significant events such as deaths. We use information from notifications to monitor the service and ensure they respond appropriately to keep people safe. However, a safeguarding concern raised by the service with the local authority had not been notified. We have made a recommendation regarding the provider reviewing their procedures to ensure they always notify CQC of significant events.

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

The service was not safe in all respects.

Risks to people's personal safety, in particular risks arising from the use of bed rails, had not all been assessed.

Whilst there had been no outbreaks of infection, infection prevention and control was not well managed. Many areas were visibly clean but some areas, including the laundry, had not been cleaned thoroughly and hygiene was difficult to maintain.

There were shortcomings in relation to checks of good character whilst recruiting staff.

Is the service effective?

Requires Improvement

The service was not effective.

Where people were unable to give valid consent to aspects of their care, the requirements of the Mental Capacity Act 2005 were not always followed.

Staff were well supported through training, supervision and appraisal.

People were protected from the risk of poor nutrition and hydration and spoke positively about the food provided.

People's health needs were kept under review and referrals were made to health and social care professionals when there were concerns.

Is the service caring?

Good

The service was caring.

People were consistently positive about the caring attitude of the staff.

Staff showed concern for people's wellbeing in a meaningful

way. They understood and respected people's individual preferences.

People were supported to make decisions about their preferences for end of life care.

Is the service responsive?

Good

The service was responsive.

People received consistent, personalised care, treatment and support.

There was a range of ways for people to feed back their experience of care and treatment at the service.

Is the service well-led?

Requires Improvement

The service was not well led.

The leadership of the service relied on external agencies to identify improvements that were needed rather than operating their own quality assurance systems effectively. Action was not always taken when audits and risk assessments identified shortfalls.

Staff morale was good, with staff confident they could raise concerns with the management team who would take the appropriate action.

Hillsdon Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 2, 3 and 11 November. The first day was unannounced. The inspection team comprised of an adult social care inspector for all three days, an inspection manager for two days and a specialist advisor in nursing for one day.

Before our inspection we reviewed the information we held about the service. This included notifications from the service about significant incidents. We did not request a Provider Information Return (PIR). A PIR is a form in which the provider gives some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we spoke with nine people who used the service, a visitor and two visiting healthcare professionals. We talked with five members of staff, the registered manager and the nominated individual. In addition, we made observations around the building and reviewed records. The records reviewed included four people's care records, medicines administration records, three staff files, training records and other records relating to how the service was managed.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. However, we found some shortfalls in how the service acted to ensure people's safety.

Risks to people's personal safety had not all been assessed. Bed rails are regularly used in care settings to prevent people injuring themselves by falling out of bed. However, they sometimes do not prevent falls and can cause injury if used inappropriately. It is therefore important that the risk of using bed rails is assessed and kept under review, to ensure bed rails are suitable for the person and can be used safely. Most people living at Hillsdon Nursing Home had bed rails up when they were in bed to reduce their risk of falling out of bed. We checked three people's care records in relation to their bed rails; there was no bed rail risk assessment for any of them.

Oxygen cylinders were not stored safely. The room they were in was not locked and they were not secured. There was therefore a risk of them falling over and also of presenting a hazard from gas under pressure. During the inspection they were chained up indoors but the chaining was not robust. The nominated individual told us at the end of the inspection that they were investigating a solution for safe storage.

Accidents and incidents were recorded and the management team reviewed individual forms for any action required. However, a recent incident form for a person with bed rails recorded that they had been found sitting on the floor having climbed over their bed rail. The suitability of bed rails for this person had not been reviewed.

The shortcomings in relation to bed rail risk assessments and the storage of oxygen cylinders were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks had been assessed and plans were in place to minimise these risks. People's individual risk assessments were reviewed regularly and covered areas such as falls, malnutrition, moving and handling and tissue viability and pressure sores. A fire risk assessment had been undertaken. Fire detection, escape routes and equipment were regularly inspected and maintained and a fire drill had most recently been undertaken in July 2016. Water temperatures were checked monthly to ensure they were at safe levels to prevent scalds and to reduce the risk of legionella infection developing (legionella are bacteria that can cause serious illness). Water samples were tested for legionella by a specialist company and the risk of legionella was assessed as low. The gas appliances had been tested and certified by a gas engineer in July 2016 and the electrical hardwiring had been inspected by a contractor in 2014.

Most areas of the home smelt fresh. However, one of the inspection team noted a slight odour to the lounge carpet. The registered manager told us this had been deep cleaned following a monitoring visit by the local Clinical Commissioning Group a couple of months before. They attributed the lingering smell to food supplements or milk that had been spilt.

Basic cleaning was undertaken around the home. A person told us, "They go round five or six times a day

with the vacuum. They keep it very clean". However, there were cobwebs in corners of some bedrooms and bathrooms. The cupboard under the sink in one bedroom was not clean. We checked the linen on the bed in this room; the bed contained crumbs and there was marked staining to the bottom sheet. There was also a stain on the carpet by the bed. We showed this to the registered manager. When we returned for the final day the vanity unit was clean, as were the carpet and bed linen.

Some areas and equipment were difficult if not impossible to keep clean. Some upholstery was frayed and worn, and some bed rail bumper covers were cracked. The broken surfaces could harbour germs even after cleaning. In the laundry the wall surfaces were pitted and the paintwork was not intact. There were no tiles above the sink, which was difficult to access due to items being stored in front of it and had a nailbrush that presented an infection control risk. There was no foot operated waste bin, meaning that staff would have to touch the bin with their clean hands to dispose of paper towels after washing their hands. Surplus equipment had been stowed in a gap between the washing machines and the wall. By the third day of the inspection the laundry sink had been tiled, but the edge of the tiled area had not been sealed and thus was difficult to clean properly.

In the laundry there was no 'dirty to clean' flow to segregate soiled and clean items. On the third day of the inspection we saw a basket of clean towels placed on top of the soiled linen bins. The nominated individual acknowledged the layout of the laundry needed to be improved, although they were constrained by the positioning of the machines.

The nominated individual confirmed there had been no outbreaks of infectious diseases.

The shortcomings in the cleanliness of the premises were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Checks were made to ensure staff were of good character and suitable for their role. However, there were gaps in the information required by the regulations and appropriate references were not always obtained. Staff files included application forms, records of interview, proofs of identity and confirmation that staff members were entitled to work in the UK. Checks had been made with the Disclosure and Barring Service (known as criminal records or DBS checks) to make sure people were suitable to work in care. However, one staff file did not contain a satisfactory written explanation of a gap of several years in their employment history, which the registered manager said was due to family responsibilities. This member of staff's DBS check was dated after they had started work. The registered manager told us they never allowed anyone to work without a DBS check and said they would place a copy of the preliminary 'Adult First' check on the staff member's file. Another staff member had no references and a further staff member had only one reference, which had been obtained from a friend living at the same address as them.

The shortcomings in relation to recruitment information and obtaining appropriate references were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient staff to meet people's care needs. People told us they generally had care when they requested it, although they sometimes had to wait at busy times, such as in the morning when people were getting up and having breakfast. Many people living at the service required care from two staff at a time. During the day, a registered nurse was on duty with four care assistants in the morning, and three in the afternoon. Staff said they were able to meet their responsibilities within existing staffing levels; one member of staff commented that staffing levels were "really good" in comparison to other care settings they had worked in. Staff absence was met through overtime rather than relying on an agency, which meant that staff who worked at the service knew the home and understood the needs of people who lived there. There were

no staff vacancies, although one member of staff was on long term sick leave.

However, the deployment of staff was an area for improvement. On one day we observed two people sitting in the lounge; during the morning staff came in three or four times to check on people over a three and a half hour period but did not spend time with them. The television was on throughout. One person started prodding at the other to wake them up but staff were not on hand to identify there was an issue. We drew the situation to the registered manager's attention. During the afternoon, staff spent time with these people.

We recommend the provider reviews their arrangements for allocating staff to support people who are spending time in communal areas.

People were protected against the risks of potential abuse. Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Information from local agencies concerned with safeguarding adults was displayed on the noticeboard in the hall for visitors and staff to see.

There were safe medication administration systems in place and people received their medicines as prescribed. Medicines were stored securely. They were checked monthly to ensure they were being recorded correctly and there were sufficient stocks that were fully accounted for.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had identified a number of people who they believed were being deprived of their liberty. They had made the appropriate applications for authorisations under DoLS, including applying to renew authorisations that had expired. They were waiting for these to be authorised.

We checked whether the service was working within the principles of the MCA. In some respects they were. Consent was obtained for various aspects of people's care, from people if they were able to give this, or from someone who had the legal authority, such as a lasting power of attorney for health and welfare, to consent on their behalf. Where people were not able to give consent about particular aspects of their care, such as having photographs taken, care and treatment and medication, staff made best interests decisions in line with the requirements of the MCA.

However, for three people whose records we checked who had bedrails there was no valid consent for the use of bed rails, nor had a mental capacity assessment and best interest decision been documented in relation to the use of bed rails. It is important that there is consent or a best interests decision under the MCA for the use of bed rails because of the associated risks and because they restrict people's freedom. We raised this with the nursing staff on the first day of the inspection and the registered manager during the second day. However, this remained outstanding on the final day over a week later.

For one person the home had provided certain aspects of care against the wishes of those who held lasting power of attorney for health and welfare. The registered manager had a clear rationale for doing so and the management team had consulted with the person's GP and with the local authority about this. However, there were no clearly documented mental capacity assessments and best interests decisions in relation to this care.

For another person, who had signed consent to their care, to having photographs and to having medicines administered, staff had completed mental capacity assessments in relation to these areas. Whilst these assessments recorded that the person had capacity in these areas, they were not necessary. The MCA states clearly that people must be presumed to have capacity unless they have an impairment or disturbance that affects the way their mind or brain works and it can be established that this means they cannot make a specific decision at the time it needs to be made.

These shortcomings in relation to consent and the MCA were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were met by staff who had access to the training they needed. People and their relatives spoke positively about the capabilities of the staff. For example, a person told us staff were capable when using the hoist and that they always felt safe when they were in the hoist sling. They also commented of one nurse in particular, "She really knows how to do her [wound] dressings". Staff confirmed they were supported to access the training they needed through online learning. New staff undertook the care certificate and their performance was monitored at work prior to being signed off by the management team. Moving and handling training was undertaken by the nominated individual, who held a current 'train the trainer' qualification. Other training provided included safeguarding adults, the MCA and deprivation of liberty, infection prevention and control and food hygiene.

Staff said they had been supported by the registered manager, both through supervision and appraisal process and informally. The registered manager confirmed that she and the senior staff regularly worked alongside others and observed them informally, although this was not documented. Registered nurses were working towards revalidation with the Nursing and Midwifery Council, which was introduced in 2015. They felt the registered manager was supportive of their professional development.

People who could told us they liked the food and were able to make choices about what they had to eat. Comments included: "[The food] could be better but it's always homemade", "Generally the plates are piled", "The meat is that deep on the plate" and "If I ask for more, if they've got any they'll bring it". Someone told us how they preferred to eat at night and that staff accommodated this: "The night staff always ask if I want something". The meals we saw looked appetising with reasonable portions.

People got the support they needed to eat and drink. Where appropriate, people had drinks readily to hand. Staff monitored people's food and fluid intake to ensure they were eating and drinking enough. Fluid monitoring charts contained target amounts of fluid to be consumed in a day and were totalled at the end of the day as a check that the targets had been met.

People's dietary needs and preferences were documented and up to date records of these were kept in the kitchen for easy reference by cooking staff. A person whose care we tracked had been identified as having swallowing difficulties that presented a risk of choking. They had been assessed by a speech and language therapist, who had devised a safe swallow plan. This was clearly displayed in their room, where they had most or all of their food and drink, for ready reference by staff. The drinks we saw were thickened to the correct consistency, which enabled the person to drink without choking.

People's risk of malnutrition was monitored regularly using a widely recognised assessment tool. Where staff were concerned about people's weight loss they acted in line with the risk assessment guidance, including pursuing a dietician referral in high risk situations. A person told us how they had been supported to gain weight having been underweight when they were admitted from hospital.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. People told us they saw the doctor when they needed to. A visiting health professional commented that staff had been organised during their visit, presenting them with the information they needed without them having to ask for it.

Good

Is the service caring?

Our findings

People and visitors were positive about the caring approach of the staff. For example, when we asked someone if staff were respectful towards them they told us, "Never anything but" and described staff as "very open". They spoke highly of a particular member of staff who they said was particularly gentle: "[Name] really looks after me". Other comments included: "They are kind to me, very patient", "They're very good to me" and "I do think it's a nice place – very caring, kind people here".

People were treated with kindness and compassion in their day-to-day care. In all of the interactions we witnessed, staff were respectful and caring towards the people they were supporting. People's dignity was respected, with staff approaching people discreetly to offer personal care, which took place behind closed doors.

Staff showed concern for people's wellbeing in a caring and meaningful way, and responded to their needs quickly. People told us staff spent the time they needed for their care and did not feel rushed. People who were able to use call bells had these to hand and call bells were answered promptly. The registered manager and nominated individual confirmed that call bell response times were checked regularly.

People received care and support from staff who had got to know them and understood their preferences. For example, people had personal effects such as photographs and ornaments on display, where they wished. One person particularly liked to listen to their radio and this was positioned in their reach so they could change channels easily. Another person told us how they were touched that a particular member of staff made chips especially for them in just the way they liked. Staff were able to tell us about people's preferences regarding their care. Where people had particular ways of communicating, staff understood this.

People's records included information about their personal circumstances and how they wished to be supported. Their views were sought through care reviews.

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed. People's choices and preferences were kept under review and were regularly updated.

Good

Is the service responsive?

Our findings

People told us their needs were met and they were satisfied with their care. Comments included: "[They do] whatever I ask", "They do keep you clean" and "They're very, very good".

People said that staff promoted their independence as far as possible. For example, someone told us about how when staff were supporting them to wash they gave them the flannel to do what they could for themselves. They also said they had the support they needed to be able to go out and about on occasions.

People had their needs assessed before they moved to the home. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care.

Care plans were thorough and reflected people's assessed needs and choices. Assessments and the corresponding care plans were organised according to headings that included maintaining a safe environment, communication, breathing, eating and drinking, elimination (continence), personal hygiene and dressing and mobility. Nurses reviewed people's care plans each month.

People's care needs were met. People looked clean and comfortable. The staff we spoke with understood people's care plans and the care and support people needed. Where people needed regular checks or repositioning, these had been undertaken. Air mattresses were set correctly for people's weights. Where people had wounds, these had been dressed in line with the person's wound management plan and the healing of wounds was monitored and recorded, including the use of photographs.

Most people were cared for in bed or in their bedroom, although we saw two or three people in the lounge during the inspection. In their rooms people had stimulation such as television, radio or music, where they wanted this.

Some group activities were provided in the lounge; for example, there was a visiting singer on the first day of the inspection and a member of care staff chatted and played games with people in the lounge on another afternoon. Staff kept an activities folder where they recorded plans for activities that people might enjoy. Recent activities had included crafts and things people had made were displayed on the noticeboard.

Complaints and concerns were taken seriously and viewed as an opportunity to improve the service. There was a complaints procedure displayed on the noticeboard in the hall. However, this incorrectly referred complainants to CQC, which does not have powers to investigate individual complaints. The management team kept a compliments and concerns file. There were no details of complaints in the past year on this file, but we were shown details of two related complaints that had been responded to.

We recommend the provider updates their complaints procedure to include appropriate bodies to receive complaints and to remove incorrect references to CQC.

Requires Improvement

Is the service well-led?

Our findings

People expressed confidence in the management of the service. For example, comments included, "They're great people running it".

However, the provider did not have effective systems in place to monitor the quality of service being delivered and to bring about improvements that were needed. Similar shortfalls to those found at this inspection had been identified through Clinical Commissioning Group and local authority contract monitoring audits earlier in 2016, yet the service had not acted on these, despite having target dates that had passed by the time of our inspection. For example, the state of the laundry had been raised at a contract monitoring visit in August 2016. Audits of cleanliness and infection control had not been undertaken. The registered manager spent most of their time on shift delivering care as a member of staff was on long-term sick leave, and so had little time to oversee the standard of cleanliness and service delivery. They told us that audits were done by the nominated individual. The nominated individual said they had relied on audits by the local Clinical Commissioning Group and social services as part of their contract monitoring process, rather than carrying out their own. They told us they had received templates for care plan and infection control audits and planned to undertake these in future.

The service's fire risk assessment from February 2014 identified a number of medium risk issues that required attention. However, some of these were still outstanding. The cleaning cupboard did not have a smoke detector or a fire-retardant strip fitted to the door. Similarly, the doors to the under-stairs cupboard and the downstairs store room did not have fire-retardant strips fitted.

The nominated individual was away on leave for the first two days of the inspection. The registered manager and staff told us documents we would need to see were locked in their office, to which they did not have a key. The registered manager did not have ready access to records they needed to meet their responsibilities as manager. They were unable to access and review quality assurance documentation to ensure people received care in a way that met their needs and kept them safe, and were unable to share these findings with external agencies, such the inspection team during their visit to the home.

These shortfalls in quality monitoring and improvement and the availability of records were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a friendly, welcoming atmosphere. There was laughter and chatter amongst people living at the service and staff throughout the inspection. Staff told us they valued working in a small home where they could get to know people and their families, comments including, "Everyone is friendly" and "I'm very happy here, like a family, I enjoy the work and give the care I would expect my family to receive". The registered manager said they were proud of treating people "like your own Mum".

The service had attained the Gold Standards Framework accreditation, a nationally recognised quality standard for end of life care. The registered manager explained how the service worked closely with the local hospice.

People and staff had confidence the registered manager would listen to their concerns, which would be received openly and dealt with appropriately. People told us they regularly saw the registered manager and nominated individual. Staff were confident in the abilities of their colleagues, for example one of them told us, "The staff is very good, that's the key". There were staff meetings every three months or so, and staff said that additional meetings were held if there was a need to discuss something in particular.

People and those important to them had opportunities to feed back their views about the home and quality of the service they received. The registered manager and nominated individual spoke regularly on an informal basis with people and their relatives. Annual surveys were undertaken of residents, visitors and staff. The most recent survey had been undertaken in November 2015 and the results were broadly positive.

The registered manager and nominated individual had notified CQC about most significant events such as deaths. We use information from notifications to monitor the service and ensure they respond appropriately to keep people safe. The service had raised a safeguarding concern with the local authority but we had not received a notification about this; services are required to notify CQC about any abuse or alleged abuse. However, other events had been notified as required.

We recommend the provider reviews their procedures to ensure they notify CQC of all significant events, including abuse or alleged abuse.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not always obtained or best interests decisions made in line with the requirements of the Mental Capacity Act 2005 in relation to aspects of people's care, in particular the use of bedrails. Regulation 11 (1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided safely because the risks posed to people by the use of bed rails were not assessed and planned for and because oxygen cylinders were not stored safely. Regulation 12 (1)(2)(a)(b)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Some areas of the premises were not kept clean and hygienic to the standard that would be expected in a nursing home. Regulation 15(1)(a)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not operate effectively to monitor the quality of the service

	and to bring about improvements that were needed. Identified shortfalls had not been acted upon. Infection prevention and control audits were not undertaken by the service to assess and manage risks of infection. Regulation 17 (1)(2)(a)(b)(d)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures did not operate effectively to ensure that staff were of good character as appropriate references had not always been obtained. The information specified in Schedule 3 to the Regulations Regulation 19 (2)(3)