Caring Homes Healthcare Group Limited

Hulcott 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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Hulcott Nursing home is a nursing home providing personal and nursing care to 19 people aged 65 and over at the time of the inspection. The service can support up to 49 people.

Hulcott Nursing Home accommodates 49 people across two floors with a communal sitting and dining room on the ground floor. People's bedrooms have en suite facilities and there is a communal bathroom and shower room on each floor.

People's experience of using this service and what we found
A person who used the service was very happy with the care provided. They told us they felt well looked after. They commented " Staff are very nice and helpful and I do not want to leave here now."

Risks to people were identified and managed, although infection control measures were not satisfactory, and some practices put people at risk.

Aspects of the service were audited but the audits were not effective in picking up issues we had identified. Some records relating to people's care were not suitably maintained and accurate.

The records and systems in the service did not support best practice on the application of the Mental Capacity Act 2005 to ensure people were supported to have maximum choice and control of their lives in the least restrictive way possible and in their best interests.

People were safeguarded from abuse and systems were in place to manage accident and incidents to ensure trends were picked up and addressed to safeguard people.

Safe medicine practices were promoted, and sufficient staff were provided to meet people's needs. Staff were safely recruited and had access to induction and training, although some inductions were incomplete, and training was outstanding. The provider had identified this and had set timescales with staff to get the outstanding training completed and inductions signed off.

The registered manager had recently left and an interim manager from another location was managing the home three days a week, until a new manager was appointed. The interim manager had completed their own review of the service and they were supporting the team to make the required improvements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 14 December 2017).

Why we inspected
The inspection was prompted by a Covid -19 outbreak at the service. A decision was made for us to inspect and examine those risks. We carried out a targeted infection prevention control inspection and found there was a concern with infection control procedures, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

This report only covers our findings in relation to the key questions Safe and Well-led. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hulcott Nursing Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches of regulations in relation to infection control practices, the application of the Mental Capacity Act 2005, auditing and records at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our safe findings below.

Hulcott Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection site visit was carried out by one inspector with a second inspector involved in gathering information from the provider in response to the Covid -19 outbreak.

Service and service type
Hulcott Nursing home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was announced on both days by phone on arrival, before the inspector entered the service.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We sought reassurances and records from the service in response to the Covid -19 outbreak.

During the inspection
We spoke with the regional manager, interim manager and deputy manager. We walked around the home to observe practice and reviewed some records which included cleaning schedules, mental capacity

assessments, medicine administration records and people's food, fluid monitoring records and turning charts.

After the inspection
We reviewed records remotely. These included five care plans, four staff recruitment files, rotas, audits, policies and other records relating to the running of the service. We set up telephone interviews with the service and spoke with one person who used the service, the interim manager, deputy manager, a nurse, a senior carer and two carers. Relatives and professionals involved with the service were given the option to give feedback on their family members care and the service. Written feedback was provided by two professionals involved with the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

● We were not assured that the provider was meeting shielding and social distancing rules. The service had not implemented zoning and cohorting best practice guidance to help prevent the spread of infection. (Cohorting means grouping people based on their risk of infection or whether they have tested positive for Covid -19 during an outbreak. Cohorting can help prevent the spread of Covid -19 in congregate living settings). People were supported to isolate in single occupancy rooms, however, there was no separation between ground floor and first floor units. In addition, the staff allocation records showed there was no allocation of dedicated groups of staff to care for people with a positive Covid-19 test or who showed symptoms. During the inspection we observed staff accessing both floors. In response to the draft report the provider told us that where possible cohorting would be encouraged in line with best practice.

● On day one of the inspection we observed a communal shower had been used. There was no system in place to put the shower room out of use until it had been cleaned and disinfected. This had the potential to increase the risk of cross infection. On day two of the inspection we saw a notice was available to indicate when the shower was used and required cleaning.

● On day one of the inspection there was no effective system in place such as signage to indicate people's Covid-19 status. The deputy manager told us staff were informed verbally during handovers. There was a risk staff would not recall information accurately or follow the required IPC measures. On day two of the inspection we saw colour codes were used on bedroom doors to indicate a person's Covid-19 status. The provider confirmed in response to the draft report that as part of each handover meeting all staff members on shift are provided with a written handover sheet which includes the COVID – 19 status of every person in the home.

● On day one of the inspection only two people were using the communal areas and therefore social distancing was able to be promoted. However, there was no signage in the lounge areas to remind people about the need to maintain social distancing and signage in the dining areas was not clearly displayed and visible to people. For example, chairs in the lounge were left positioned next to each other and the dining room, was set for three to four places per table which did not allow for adequate social distancing. On day two of the inspection we saw social distancing was promoted in communal areas, with armchairs spaced and the dining tables only set for one person.

● We were not assured that the provider was using Personal Protective Equipment (PPE) effectively and safely. On day one of the inspection three out of 12 PPE stations were not kept stocked with the required PPE. This meant staff supporting people did not have immediate access to the correct level of PPE. The provider reassured us after the inspection that there was plenty of availability of PPE despite the PPE stations not been kept stocked. On day two of the inspection we saw one staff member was allocated to check and stock PPE stations throughout their shift. The PPE stations were generally better stocked

although some were low in stocks of masks and red bags. The interim manager agreed to make a list available to outline what each PPE station should contain and put a notice at each PPE station to make it clear where those PPE stations were located.

● The service did not ensure that all staff received Covid-19 Infection Prevention Control and PPE training in a timely manner. Mandatory Coronavirus (Covid-19) Infection Prevention & Control training on Donning and Doffing (PPE) training was required from the 1 April 2020. However, the training completion list provided showed that several staff did not complete this training until late into the pandemic. For example, completion was delayed between 20 September 2020 and 20 December 2020 for 10 long standing members of staff out of 32. This meant the service could not be assured that all staff understood these requirements to reduce the risk of infection.

● The service had a named IPC champion who had completed external Covid-19 IPC/PPE training in May 2020 with the Clinical Commissioning Group, in order to deliver the same training to staff internally. However, the assessment records showed a delay in cascading the training. Seven staff were trained on the 12 July 2020 and other training records showed the same seven staff were trained in PPE on the 19 October 2020. The deputy manager told us 'short sessions' were provided by the IPC lead to additional staff members during handover meetings. However, records were not available to evidence this.

● The deputy manager confirmed staff were required to have completed mandatory 'Handwashing Protocol to Help Prevent the Spread of Infection' training. However, records were not available to evidence this. A handwashing competency assessment list showed all staff had been assessed between 22 and 27 December 2020 and the provider confirmed in response to the draft report that effective handwashing technique is part of the Infection Control training, which includes an end of course assessment. They advised the report of this training had 92% completion across all staff members.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We saw red bags containing used cleaning equipment were left on the carpeted floor outside bedrooms of people who had tested positive for Covid-19. The staff member removed them when prompted to do so. High touch areas were to be cleaned every two hours. However, records showed high touch areas were only cleaned up until early afternoon and only once at the weekend. The deputy manager told us the care staff completed the cleaning when the domestic staff are not on shift. However, this was not recorded and there was no system in place to ensure this was achieved. On day two of the inspection the cleaning records showed high touch areas were cleaned more frequently and a staff member was allocated to do this task on shift when the domestic staff had finished their shift.

● We were somewhat assured that the provider's infection prevention and control policy was up to date. Following the inspection we were provided with a copy of the provider's 'Coronavirus (Covid-19) Infection Prevention and Control' policy and procedure. The information contained within it was not up to date with Government guidance. The provider confirmed in response to the draft report that the policy that was shared with us was not the most up to date policy. They provided us with a copy of the managers pack which included links to the infection control policy, a Covid-19 business continuity plan, links to government guidance and standard templates and letters to be used by the home in relation to the pandemic.

● At the time of the inspection we were provided with a 'Generic Covid-19 Risk Assessment' which gave general guidance on managing the risk of Covid-19, as opposed to it been specific to the home. In response to the draft report the provider sent us a risk assessment for the service which had been signed by the previous registered manager in October 2020. We saw a risk assessment for the use of face masks, dated 17 April 2020, was in place. This had not been reviewed and lacked specific information about what type of PPE was required, for example it stated "Appropriate PPE should be used for all residents with a confirmed or suspected case of Covid-19 as stipulated in Government guidance. There was no reference to whether staff needed to wear PPE at all times in the care home, in line with the PHE guidance on Personal protective equipment. In practice we saw staff wearing the appropriate level of PPE in the home however, we were concerned that the homes risk assessment was not being kept up to date with changes and the most recent

guidance.
●The previous registered manager completed a weekly 'Business Continuity Plan Covid-19 – Coronavirus Planning Checklist'. The completed checklists dated 30 November 2020, 7 and 12 December 2020, all stated "Home manager and deputy manager taking the lead on this. Housekeeper and team are aware of extra cleaning schedules and these are being strictly followed daily. One nurse has had some infection control training through Buckinghamshire Council and will undertake small training sessions in house to pass on what she has learned. New infection control audit to be completed monthly." However, there was no check to review whether the roll-out of training had been achieved or whether cleaning schedules were being completed.
● We were somewhat assured that the provider was making sure infection outbreaks could be effectively prevented or managed. During the outbreak of COVID -19 the regional manager had liaised with PHE. At the site visit of the 17 December 2020, the regional manager told us that staff sharing taxis to work was a likely source of the outbreak, however, no root cause analysis had been undertaken. After our inspection the regional manager provided an 'Outbreak Report', dated 18 December 2020, which identified a potential source of staff sharing taxis as well as high touch point cleaning not being fully complied with. We were concerned this was not a comprehensive review or timely response to the outbreak which started on 28 November 2020. This meant that potential gaps in policies, procedures and staff implementation were not effectively reviewed or amended in response to the outbreak and reduce the spread of infection. The provider confirmed in response to the draft report that the review was delayed because members of staff who needed to be interviewed were self-isolating and unavailable until that time to ascertain the full facts of the matter in order that the review could be undertaken.
● We were somewhat assured that the provider was accessing testing for people using the service and staff. The service supported people and staff to access regular testing, however, Mental Capacity Assessments (MCA's) and best interest specific decision processes were not followed or recorded for people who may meet the criteria for assessing their capacity.

The service had failed to ensure appropriate infection control measures in response to the Covid-19 pandemic. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection to outline improvements to infection control practices.

● We were assured that the provider was preventing visitors from catching and spreading infections. Visitors were required to complete a questionnaire, have their temperature and oxygen levels taken and lateral flow tests had just commenced for visitors to the home. Family visits had been suspended due to the current outbreak of Covid-19, but they were putting safety measures in place to enable that to commence in the future in line with government guidance.
● We were assured that the provider was admitting people safely to the service. At the time of the inspection they had suspended admissions due to the outbreak of Covid-19 but told us people admitted to the home would have to have a negative Covid-19 test and would be isolated for the required time.

Systems and processes to safeguard people from the risk of abuse
● Staff were trained in safeguarding procedures. The provider had identified updates on this training was required for some staff and this was being addressed. The organisation's and the local authority's safeguarding policies and procedures were displayed on the notice board and accessible to staff and people who used the service.
● Staff were aware of their responsibilities to report poor practice and concerns. They confirmed they had

received safeguarding adults training. A staff member commented "I would report any concerns immediately to my manager and would follow up on it to make sure the person was safe."

Assessing risk, safety monitoring and management

● Risks to people were identified and managed. People's care plans showed that risks such as moving and handling, falls, pressure areas and risks associated with medical conditions such as diabetes were identified and managed. Staff were aware of people's needs and risks and knew what to do to promote their safety. During discussion with them they were able to identify individuals with specific medical conditions, at risk of choking or a high risk of falls. The care staff were clear that If they had any concerns about individuals, they would inform the nurse in charge immediately for them to assess the person.

● The service had an environmental risk assessment in place which was up to date and reviewed. The provider's audit and health and safety meeting minutes indicated electrical equipment and gas safety checks were carried out. Legionella testing was up to date. Moving and handling and fire safety equipment was serviced. People had personal emergency evacuation plans (PEEP's) in place and regular fire drills took place. A recent fire safety review had identified areas for improvement. This was been addressed by the organisation.

Staffing and recruitment

At the previous inspection a recommendation was made for the provider to ensure systems were in place to monitor recruitment of staff.

● At this inspection we found staff were suitably recruited. They completed an application form, were interviewed and pre-employment checks were carried out. These included references from previous employers, a medical questionnaire and disclosure and barring checks. The provider confirmed staff files included a recent photograph, although this was not included on staff files viewed electronically. Registered nurses were checked against the Nursing and Midwifery Council register (NMC) to ensure they were registered and fit to practice.

● The service had a reduction in the number of people living at the service. The rotas showed there was sufficient staff to support people. There was generally two registered nurses and five or six care staff on the day time shift and one registered nurse and three care staff at night. Alongside this the home had administration support, housekeeping and catering staff.

● People's dependency levels were kept under review and updated monthly to enable the service to satisfy themselves that they had sufficient staff on shift to meet people's needs. The home had used agency staff to cover staff sickness during the Covid-19 outbreak, but as permanent staff had returned from isolation their use had reduced. The interim manager and deputy manager were not included on shift and they were available to support if required.

● Staff confirmed the staffing levels were sufficient and that the management team also supported on shift if required.

● The training matrix showed some gaps in training which the interim manager confirmed was being addressed. Staff told us they felt suitably trained and supported to do their job. They confirmed they had received an induction and continued to have access to regular training and updates.

Using medicines safely

● Systems were in place to promote safe medicine practices. Medicines were suitably stored and at the recommended temperature. Records were maintained of medicines ordered, received, administered and disposed of. Stock checks and monthly audits of medicines took place to ensure sufficient medicine was available and to check that medicine was given as prescribed.

● The provider had a medicine policy in place which promoted safe medicine practices. Registered nurses

administered medicines and training records showed they were suitably trained and assessed to carry out that task.

● In medicine administration records viewed we saw medicines were given as prescribed. However, for one person their medicine administration record showed their prescribed emollient cream was not applied as a minimum twice a day (as prescribed) and it was not clear if a second "as required" emollient cream was to be administered at the same time as the other emollient. The topical medicine administration (TMAR) record showed dates where they were both applied in the morning. The interim manager agreed to address this.

Learning lessons when things go wrong

● Accident, incidents and complaints were recorded, and these were reviewed to enable trends and recurrent accidents/incidents to be picked up. Monthly clinical governance meetings took place which picked up on changes in people. We saw there was an increase in falls for a person and this was acted on and a referral was made to the GP.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider had a quality governance policy in place and there was a schedule in place which outlined the frequency of audits. Aspects of the service were audited such as call bells, housekeeping, meal times, catering, medicines and care plans. Alongside this the provider carried out monthly monitoring visits. The audits viewed had not picked up issues we found in relation to infection control practices outlined under the safe domain and records as outlined below.
- The monthly 'Covid-19 Audits', were repetitive in their findings and had not been effective in identifying the shortfalls we found during our inspection. For example, audits on the 14 October 2020, 13 November 2020 and 9 December 2020, all identified in response to the audit statement "There is evidence of social distancing of residents in communal areas such as dining rooms and sitting room" that it was "Difficult at times due to the size of the area." There was no action taken in response to this to improve the situation. However, following our inspection the service took action to rearrange furniture and improve signage.
- People's care records were not always contemporaneous, accurate or complete. People's care plans outlined if an individual's food and fluid was to be recorded and monitored. The fluid charts viewed did not always indicate the fluid target required and where this was identified it was not achieved. For example, one person's fluid target was 2500 millilitres over 24 hours, but the records viewed showed this had not been achieved with their fluid intake ranging from 450 millilitres up to 1450 millilitres over 24 hours. A person considered a high risk of pressure damage was required to have their position in bed changed every three to four hours. The record showed occasions where it was not recorded that the person was turned at that frequency. On one occasion the turning charts showed seven hours between turns although their daily records showed staff intervention during that time which would suggest their position was changed. The lack of accurate records had the potential to put people at risk of dehydration and pressure damage and had not been identified by the provider's own audits. The provider confirmed in response to the draft report that this was an isolated incident and not a theme regarding repositioning of people.
- The care plans viewed lacked detail as to the level of support people required with their personal care. They indicated staff were to assist with personal care, or two staff were required to meet personal care needs. For a person on end of life care it was recorded to 'keep comfortable and maintain dignity' and for another person it indicated they required a bed bath but there was no specific detail provided as to how this was to be carried out in a person-centred way. Another person's personal hygiene care plan made reference to them having a bath. However, it was not outlined if this was daily and if not what level of personal care was required on other days.

● For another person their care plan did not outline how behaviours that challenged presented or were to be managed, other than indicating that staff were to distance themselves and return when the person was in a better frame of mind. The evaluation of the care plan indicated episodes of behaviours that challenge had occurred in the month, but no detail was provided as to what that was.
● Some care plans were contradictory. For example, the front page of a person's personal hygiene care plan indicated they required the assistance of one staff member to meet personal hygiene needs, however under the desired outcome section it was recorded the person required two staff to meet their personal hygiene needs. Their care plan on sleep under morning routine stated they required assistance of one staff member for personal care.
● Another person's care plan indicated they required a normal diet. However, a note was added to the end of the care plan to say they were now on a pureed diet. The care plan was then not updated to reflect that and had the potential to be contradictory and put the person at risk.

Records were not suitably maintained, and audits were not always effective in identifying areas for improvement. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection to outline improvements to record management.

● Staff involved in mental capacity assessments were trained. However, the records viewed showed a lack of understanding and application of the Mental Capacity Act (MCA) 2005.
● Decision specific MCA and best interest decisions were not routinely completed for people who lacked capacity to make decisions. For example, people who lacked capacity did not have a mental capacity assessment completed for aspects of care and treatment such as medicine administration, personal care, Covid-19 testing and vaccinations. The MCA for Covid-19 testing was completed after people had already been tested. The deputy manager told us they were not aware that MCA and best interests processes were required for Covid-19 testing and the providers consent to the testing and vaccinations template did not prompt staff to take the MCA into account.
● In one person's file we saw a Deprivation of Liberty Safeguard referral for the use of bed rails was made on the 27 May 2020, however the mental capacity assessment for this decision was not completed until the 2 June 2020 and the bed rails risk assessment was not updated until the 18 August 2020, where it indicated the next of kin was informed.
● In the person's professional contact record, it included an entry to say a registered nurse from the service had a telephone conversation with the next of kin and the next of kin had agreed to sign the dental referral. There was no indication that this was referred to the referring professional for the decision to be made in line with the principles of the MCA 2005.
● Some completed mental capacity assessments were not fully completed to indicate if the next of kin was consulted with or not. Where this was recorded it indicated the GP and or next of kin was informed rather than consulted.

This is a breach of regulation 11 (Consent to care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
●The registered manager had recently resigned and a manager from another location was managing the service on an interim basis. They planned to be in the service three days a week and had applied to the Commission to have this location added to their registration.

● The interim manager presented as keen, enthusiastic and knowledgeable and was looking at improving records such as cleaning templates and food and fluid records to benefit people and the running of the service.
● Staff felt the service was well managed. They described the management team as "approachable, accessible and with an open-door policy."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Systems were in place to get feedback from staff, people who used the service and their relatives. Surveys were carried out in October and November 2020. An action plan was in place to address some of the feedback from staff although, feedback around the inconsistency of supervisions and team meetings were not referred to on the action plan. Staff confirmed they received supervision and records were available which showed regular team meetings took place.
● Systems were in place to promote good communication. A variety of team meetings took place which ensured staff in all roles were informed of key issues. Daily handovers took place and a handover record and allocation sheet were in use to ensure staff were clear of their responsibilities on shift. On day two of our inspection we saw the allocation sheets were more specific as to which staff took responsibility for ensuring the PPE stations were suitably stocked and that a care staff member was allocated to cleaning high touch areas when the cleaning staff had finished their shift.
● Staff felt communication was good and they worked well as a team. A staff member described the team as "A family who all pulled together and supported each other."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had a duty of candour policy to support staff in meeting the regulation. It indicated people and their relatives were to be provided with a written explanation and apology following a safety incident.

Continuous learning and improving care
● Staff had access to induction and mandatory training. The provider had identified some gaps in training for staff such as safeguarding training and the need for new staff to complete their induction workbook. Timescales were set to address this.

Working in partnership with others
● The service worked with a range of health professionals to enable them to support people with their health and medical needs. A health professional told us they had no concerns about the end of life care provided to a person. They commented "Staff were friendly, respectful and caring to the patient and the nurse was very professional and gave very good end of life care to the patient." Another professional told us they had worked closely with the service in providing training. Nutrition champion leads were identified and they acted as a resource to other staff in dealing with queries on nutrition. The professional commended that within the training sessions "They had some fruitful discussions."

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 The service was not working to the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Infection control practices and measures in place, were not always in line with guidance which had the potential to increase cross infection within the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not suitably maintained, and auditing was not effective in identifying the issues we found.