Springfield Health Services Limited

Springfield Nursing and Residential Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 4 March 2015 and was unannounced.

Springfield Nursing and Residential Care Home is registered to provide accommodation, nursing and personal care for up to 65 older people and people who may be living with dementia. At the time of our inspection there were 54 people living at the home. They were accommodated in two buildings, House 72 for people whose needs were less complex and House 74 for people with more complex nursing needs. Each house had a shared lounge, dining room and an enclosed garden. There were two double rooms, one of which was occupied by one person at the time of our visit.

The registered manager had left six weeks before our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

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. The provider had appointed a registered manager from another service to manage both homes as group manager, but they were not formally registered for Springfield Nursing and Residential Care Home at the time of our visit. They sent the application form to address this the day after our visit. They are referred to as "the manager" in this report.

People did not always experience care and support in a prompt manner when they asked for assistance or used the call bell system. People were satisfied overall that the care and treatment they received met their needs and took into account their choices, likes and dislikes. Records showed treatment for conditions such as pressure injuries was effective.

People were protected against the risk of avoidable harm and abuse, and against other risks to their safety and wellbeing. The service identified and managed individual risks and had plans in place for emergencies which might affect the whole service.

At our last inspection in August 2014 we asked the provider to take action to make sure there were sufficient suitably qualified and experienced staff to support people safely. They sent us an action plan which they had completed by the time of this inspection. People were supported by enough suitable staff to meet their needs and keep them safe. The provider had recruitment procedures in place to make sure staff were suitable to work in a care setting.

People were protected against risks associated with medicines because procedures were in place and followed to store, handle and administer medicines safely.

Staff were supported to provide care to the required standard by appropriate training, supervision and appraisal. Staff sought people's consent before they supported them with their care, and the service followed legal requirements where people did not have capacity to make a particular decision.

Where people needed support to maintain a healthy diet, this was provided. The food offered was prepared and presented in an appetising way. There was choice of meals and drinks, and people were encouraged to take sufficient fluids. People were supported to access other healthcare services when necessary.

Staff established friendly, caring relationships with people. People's views were listened to and they were able to take part in decisions about their care and support. Their privacy, dignity and independence were respected. Staff received suitable guidance about equality and diversity.

The care and treatment people received was based on plans which focused on the person as an individual and contained information about their history, preferences and views. People's rooms were decorated with personal belongings and photographs, and they were assisted to identify their own room by photographs and other personal details on the door. People were supported to take part in a variety of individual and group activities according to their choices and preferences.

There was a caring, friendly atmosphere in the home. People felt able to speak openly to both staff and the manager. The manager had identified actions to improve the quality of service provided and had established a management style which was appreciated by staff. There was a system of internal checks and audits, and quality surveys which were intended to let the manager monitor the quality of the service and identify improvements.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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?
The service was safe.

Procedures were in place to protect people against the risk of avoidable harm or abuse. Risks to people's safety were assessed and managed.

People were supported by sufficient numbers of staff whose suitability for working in a care setting was checked before they started work

People's medicines were stored and handled safely.

Good

Is the service effective?
The service was effective.

People were supported by staff with the necessary skills and knowledge.

Care and treatment were provided with people's consent. Where they were unable to consent, the service followed legal guidance to ensure decisions were made in their best interests.

People were supported to eat and drink enough. They could access other healthcare services when necessary.

Good

Is the service caring?
The service was caring.

There were caring relationships between people and the staff supporting them.

People were able to express their views and were involved in decisions about their care.

People's privacy, dignity and independence were respected.

Good

Is the service responsive?
The service was not always responsive.

People did not always receive prompt support when they used the call bell system.

People's care and treatment were planned and delivered in a way that treated them as individuals and met their needs. People were able to take part in activities which interested them and reflected their preferences.

The service responded to comments and complaints to improve the service.

Requires Improvement

Is the service well-led?
The service was well led.

Good

Summary of findings

There was an open, caring atmosphere with an emphasis on team work and care which treated people as individuals.

Staff and people responded well to the new manager's style. The manager had identified areas for improvement and was carrying out the necessary actions.

Systems were in place to monitor and improve the quality of service provided.

Springfield Nursing and Residential Care 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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on 4 March 2015 and was unannounced. The inspection team comprised two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we had about the service, including previous inspection reports, action plans and notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law.

We spoke with 13 people who lived at Springfield Nursing and Residential Care Home and four visiting relations. We observed care and support people received in the shared area of the home. We used our Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the manager, the deputy manager, the home services manager, training manager, two nurses, a team leader, three care workers, and kitchen and laundry staff. We spoke with a visiting healthcare professional.

We looked at the care plans and associated records of six people and medicine records for four people. We reviewed other records, including the provider's internal checks and audits, training records, three weekly staff rotas, an organisation chart, the manager's action plan, records of meetings and staff supervisions, and six staff recruitment records.

Good

Is the service safe?

Our findings

All the people we spoke with said they felt safe living at the home. One person was at risk of falls and now used their bathroom only when a care worker was nearby. This had been arranged with them and they understood it was to keep them safe. We saw staff took account of people's safety, for instance when helping them to move about the home. Staff used appropriate equipment to help people move, made sure they were positioned safely and explained all the time what they were doing.

When we inspected Springfield Nursing and Residential Care Home in August 2014 we found there were not enough skilled, qualified and experienced staff to meet people's needs which meant they were not compliant with the relevant regulation. We judged this had a minor impact on people and required the provider to send us an action plan showing how they would meet minimum standards in this area.

On this occasion we found improvements had been made. The provider had recruited more staff, and although recruitment was ongoing this was mainly to build a bank of temporary staff to cover absences. The provider had reduced their dependency on agency staff and only three shifts had been covered by agency staff in February 2015.

The manager had determined staffing levels based on feedback from people, their relatives and staff. Three rotas covering the weeks before our inspection and other records showed these staffing levels were maintained, and staff confirmed this. Staff recognised that improvements had been made and they said they were "busy" but able to manage their workload. A care worker commented that they were "always busy", but there were always the right number of care staff on duty. One visiting relative said staffing was "much better". Another relative said they had raised concerns about staffing with the new manager who was "taking them seriously". We saw staff were able to carry out their duties in a calm, professional manner. If two care workers were needed to attend to a person, there were two available.

The manager told us they were continually reviewing staffing levels in accordance with people's changing needs. They planned to introduce an additional care worker to cover a busy period in the mornings. Additional staff had been recruited and would be starting in the near future.

Staff were aware of the risks to people of avoidable harm and abuse. They knew about the different types of abuse and were able to give us examples of signs and indicators they looked out for. They were informed about their responsibility to report any concerns, aware of the procedures to follow, and confident any concerns or allegations would be dealt with by the manager and senior staff. They were also aware of contacts in outside organisations where concerns about people's safety could be raised if necessary.

The provider arranged regular training for staff in safeguarding and had appropriate procedures and policies in place. There had been no concerns or allegations raised since the manager had been in post, but they were aware of their responsibilities to report and investigate them where appropriate. They told us they considered there were open communication paths and staff could raise any concerns with them.

The provider had risk assessments and procedures in place to follow in the event of an emergency such as fire. Staff were aware of these and how they should respond if the fire alarm sounded. The fire evacuation plan took into account the individual needs of people who staff helped with their mobility.

Risk assessments were in place. They identified risks including those associated with first aid, activities, and specific areas of the home such as the kitchen and laundry. The assessments included a definition of the risk, the likelihood of it occurring, the severity of its effect, and control measures in place to manage and reduce it. Action plans were in place to keep people safe and comfortable in hot weather. People had individual risk assessments associated with moving and handling, use of mobility aids such as wheelchairs, and risks of falls.

If accidents or incidents did occur, staff completed a standard form which was reviewed and followed up. Steps were taken to prevent the same thing happening again, and follow up actions were recorded. These included any treatment of wounds sustained in the accident and a period of observation in the days following a fall.

We discussed the provider's recruitment process with the manager and found them to be robust. Records showed that the necessary checks were made about candidates' identity, previous employment, qualifications, and suitability to work in a care setting.

Good

Is the service safe?

Medicines were stored and handled safely. We observed a medicines round. The nurse wore a red "do not interrupt" apron. They observed suitable hygiene practices. The nurse encouraged people to take their medicines, explaining what they were for. One person was restless and possibly in pain. The nurse offered them pain relief, but they declined and their wishes were respected. This was recorded on their medicine administration record (MAR). Medicines were administered from blister packs. Where people had crushed medicines because of difficulties swallowing, this was approved by their GP. MARs contained signatures of staff to show they had read and observed the home's policy for safe handling and administration of medicines. There was a summary handover medication checking sheet which was signed by the nurse in charge at the end of each round.

We checked four people's MARs. They contained the person's name, photograph, date of birth, and if they preferred to administer their own medicines. Records were accurate and up to date. "As required" medicines were recorded with the time, nurse's signature and the reason for giving. There were separate charts for prescribed creams and ointments. Information was included about allergies and how to recognise if people were in pain.

Suitable arrangements were in place for storing medicines, including those that needed to be kept below room temperature. Staff checked and recorded the refrigerator temperature and the surrounding temperature where the medicines trolleys were kept. This made sure medicines were kept according to the manufacturer's instructions. Medicines trolleys were locked when not in use and cleaned weekly. When the pharmacy delivered medicines, they were checked and signed for.

Good

Is the service effective?

Our findings

People and their relatives were satisfied staff had the skills and knowledge to support people. One person said, "The staff are excellent". Most people were happy with the quality and choice of food. One person said, "I'm very happy here. We have a choice of food if there is something we don't like, but I eat all my food." Another person said they found the food "bland". People were supported to access healthcare services if they needed them. They said GP visits or hospital appointments were arranged "quickly and efficiently". Relatives were happy they were kept informed of changes to their family member's health.

People and their relatives raised no concerns about the ability of staff to support people according to their needs. Staff were satisfied they received appropriate and timely training and had regular supervision meetings with senior staff. One care worker had recently joined from another home owned by the provider. They were working alongside a team leader until they were familiar with the people and procedures in this home. They confirmed they had a job description and training plan which included working towards gaining a recognised qualification in social care and team leading. Their training plan was regularly reviewed and updated. A second care worker spoke positively about their training plan.

The manager worked with the provider's training manager to maintain training plans and records. We saw records of courses planned, booked and completed. Staff told us training was followed up by tests of knowledge retained, and key messages were reinforced in supervision meetings with their line manager. Staff were able to raise training and development needs in supervision sessions.

The manager and training manager were reviewing training which was from a variety of sources including the local council, a nearby college and self-study. They had identified a number of mandatory courses which included moving and handling, mental capacity and deprivation of liberty. The training manager was updating the 12 week induction programme to incorporate the Care Certificate, which defines the learning, competencies and standards expected of people working in adult social care.

Records were in place to show staff had regular supervision meetings. The content of these meetings included a review of achievements, identified learning, challenges, personal development needs and progress, and targets to achieve before the next supervision. Supervision meetings were delegated to senior care staff overseen by staff nurses. Senior staff received appropriate training in team leadership.

Staff sought people's consent for care and treatment. Where people were able to consent, this was documented in their care plans. People signed their consent forms if they were able to do so. Family members were involved in discussions when appropriate. Consent forms were in place both for day to day care and support, and for other decisions such as whether to use bed rails if the person was at risk of falling from their bed. Care staff were aware of how to interpret people's body language and facial expressions if they were not able to communicate their consent through speech.

Where people lacked capacity to make decisions staff were guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests. The Act provides the legal framework to assess people's capacity to make certain decisions, at a certain time. Capacity assessments and best interests decisions were recorded in people's care plans. Staff reviewed capacity assessments monthly in line with people's care plan reviews.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. We found the home to be meeting the requirements of the DoLS. Applications had been made to the local authority as the Supervisory Body to make sure that where people were deprived of their liberty this was done in their best interests and was the least restrictive way of keeping them safe.

People were supported and assisted to maintain a healthy diet. Most people were complimentary about the food provided, although one said they would like curry and another found the food bland with not enough salt. Other people said the food was good, and a visiting relative said, "The food is never bad".

Staff told us the menu offered was based on a four week cycle. It was circulated the day before so people could make their choices. If there was nothing people liked, they could have an alternative, such as a jacket potato or

Good

Is the service effective?

omelette. We saw lunch being served. Care was taken to make sure food was warm and served promptly. The setting of the dining room was pleasant and staff helped to make it a pleasant experience for people.

Care staff were aware when people were at risk of poor nutrition and gave examples of how they could encourage people to eat. Records showed other professionals such as dieticians and speech and language therapists were consulted if people were at risk or had difficulties swallowing. People's food was prepared according to their needs and choices. The kitchen had a chart showing people's individual medical requirements and preferences. These included where people needed a diabetic diet, soft food, particular portion sizes, and their individual likes and dislikes.

A comments book was available for people or relatives to provide feedback on their food, and we saw the home had been given a rating of "very good" for food hygiene by the local authority.

People's health and wellbeing were supported by access to healthcare services when needed. These included GP, district nurse, specialist nurses in skin care, diabetes and continence, and physiotherapists. Records in people's care plans showed hospital appointments and GP visits were arranged in a timely fashion.

Good

Is the service caring?

Our findings

There were caring relationships between people and staff who supported them. People described staff as "very friendly", "here to help" and "excellent". One person said they had "no issues with the staff". A visiting relative said staff were "friendly and approachable" and, "The manager always comes over for a chat."

People were treated with kindness. Staff explained what they were doing, and why, for instance when using a hoist to help a person move. Staff called people by their preferred names and gave time for them to move from one position to another. They made eye contact with people by getting down to the person's level if they were sitting. They spoke clearly and at a volume which could be heard but was not too loud. They used encouraging gestures and facial expressions, and remained calm. People were able to do things at their own speed. We heard a care worker say, "There's no hurry. You can slow down if you like." Another care worker described how they got to know people: "I tell them who I am and reassure them." They said they could recognise how people felt by their movements and facial expressions.

People told us they saw the new manager or deputy manager almost every day. "They walk around the floors and stop to say hello." They saw this as a positive sign that the managers cared.

Staff kept people's families informed about their relative's care. These contacts were recorded in people's care plans, for instance staff let a person's family know when an occupational therapist's report was ready following their visit to the person. Another person's relative told us they were "consulted quickly" if staff had any concerns about their family member.

Everybody we spoke with confirmed they were able to make choices about their daily routines and they were happy they were "in control" of their care. This included whether they stayed in their rooms or joined other people in the shared areas of the home, whether they had meals in the dining room or in the privacy of their own room and what they wanted to wear. For example, one person said they felt in control of their medicines. They said, "I know what most of my tablets are for. I take about 15 of them." People and their families were involved in advance care decisions, such as their care and support as they approached the end of their life. Advance decisions ensure that people's views can be respected at a time when they might not be able to communicate them.

People and their relatives all agreed that people were treated with dignity and their privacy and independence were respected. People told us staff always knocked before they entered their bedrooms, and that they asked permission "before they did anything". We saw staff treated people as individuals, and took care about their appearance and clothing to maintain their dignity.

Staff told us nobody living at the home had particular needs or preferences arising from their religious or cultural background. They were aware of some of the adjustments to people's care that could arise from this. The provider had a relevant policy about equality and diversity. Care plans were designed to take into account any preferences arising from a person's religious or cultural background.

Requires Improvement

Is the service responsive?

Our findings

Although people were satisfied the care and support they received met their needs, some were dissatisfied with the time it took for staff to respond to their requests for assistance. Others told us of minor examples of care and support not reflecting their preferences or needs at the time. One person said, "The care is a bit erratic from one day to the next. I would like for someone to notice me. For instance I want my lip salve and I can't reach it. I just want to lie on my bed and it hasn't been made." Another said, "Everything is fine, but I have to wait an hour to go the toilet." Two members of staff were concerned that people were not always able to get up at their preferred time because staff were busy elsewhere.

A number of people told us they had to wait after pressing the call bell:

- "I'm often waiting for half an hour for someone to come."
- "Last week I used the emergency buzzer and was told off."
- "… waiting for half an hour to go to the toilet."
- "Wait time varies, can be 10 to 15 minutes but sometimes much more."
- "Pressed the buzzer and no answer, so I pressed the alarm."

One person said it was particularly bad between 6am and 7am when "no-one comes". Several people told us they resorted to using the emergency bell if there was no response to their initial call for assistance. Two people were concerned that if they fell in their bathroom they would not be able to call for assistance.

During our inspection we noted that responses to the call bell were not immediate, but not too long delayed. On one occasion a person pressed the emergency call because they had fallen; staff responded quickly to this. We asked the manager if there were data from the call bell system which showed how long it took staff to respond. This information was not collected, but the manager was aware of problems in this area and was taking action, for instance by adding an additional care worker to the rota for the early morning.

Failure to provide care and support that met people's needs in a timely fashion was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also received positive comments about the care and support provided. A visiting relative said, "I am really, really happy with the care. I can't fault it. I am in here three or four times a week." Some people were very independent and needed little assistance with their personal care. They confirmed they managed their own days and only asked for help when they needed it.

Care and treatment were provided based on care plans that were centred on people as individuals and were updated regularly and in line with their changing needs. Guidance on helping people meet their personal needs and outcomes were identified, such as "make the most of [Name's] sociable days". People's preferences for their daily newspaper, waking and sleeping routines, food and drink, social interactions and interests were recorded. People's rooms were decorated with their own belongings and photographs. The door to their room was also personalised with a photograph and information about the person's life and interests. This would help people living with dementia to identify their own room independently.

Care plans covered areas such as the person's general health, medicines and medical care, mobility, and mental health. These were reviewed every month. There was also a monthly clinical governance audit which reviewed people being treated for pressure injuries, people who had lost significant weight, people admitted to hospital, safeguarding incidents, accidents and complaints. Medical observations (temperature, blood pressure, pulse and weight) were made and recorded every month, and people's risk of poor nutrition and of acquiring a pressure injury were assessed monthly. Care plans were reviewed with the person's family every year.

Records were kept which showed how people responded to treatment for pressure injuries and other wounds. In one case the person's wound had reduced in size by half, and in another the person's GP had been involved and the wound was being checked every day.

People's care and treatment were changed in line with their changing needs. Following a medicines review with their GP, one person's medicines had been changed to "as required" from being prescribed daily. Another person had

Requires Improvement

Is the service responsive?

indicated they no longer wished to administer their own medicines, and the service had responded to this. Staff had changed the care plan for a third person as their ability to move about independently had changed.

People's wellbeing was promoted by appropriate activities and entertainments. There were two activities coordinators on duty during our inspection. We saw them assisting people with individual, tailored activities. For example, a person was painting watercolours and small groups of people were reminiscing about musicals or playing Scrabble. Other people participated in a charity coffee morning which gave them the opportunity to chat with other people in a pleasant environment with piano music. One person celebrated their birthday.

There were planned activities each morning and afternoon. There were opportunities for sitting exercises, and a Pets as Therapy dog visited the home regularly. Previous events such as garden parties, fetes, a visit by tame owls and celebrations of Valentine's Day and St George's Day were recorded by photographs which allowed staff to use them to help people remember and reminisce. People were appreciative and complimentary about the opportunities to take part in activities which were meaningful to them.

People were aware they could make comments or complaints about the service formally and informally. They said they would have no issues about raising concerns with any staff member. Visiting relatives were complimentary about communications with the manager and how they responded to comments. One relative said, "I only had concerns at the very beginning. They have taken on board everything I said."

The provider's complaints procedure was displayed at the entrance to the home. There was a complaints file which showed complaints had been investigated and responded to. Following complaints about a person's care, their care plan had been reviewed in consultation with their family and changes made to make sure they received care and support that met their needs.

Good

Is the service well-led?

Our findings

People were complimentary about the atmosphere and culture in the home. They found it welcoming and friendly. One said, "The place is lovely. I'm tip-top. As soon as you walk into the place it's got a lovely calm feel." Relatives confirmed they were able to visit at any time, were made welcome and given the opportunity to eat with their family member if they were there at a meal time. Relatives were happy with the communication they received both individually and by means of meetings and their minutes. They were consulted regularly about the quality of the service.

Staff had responded positively to the appointment of the manager. A staff nurse told us morale was good and staff were well supported. The manager told us their vision was to make sure people were cared for in a "lovely, warm, safe friendly environment". They were communicating this to staff. We saw the minutes of a staff meeting held in the month before our inspection. It emphasised team work and delivering care and support that treated people as individuals. There was a key worker and named nurse system in place which meant people had identified staff members responsible for making sure their care met their needs and was delivered according to their preferences. The manager had identified a staff champion for infection prevention and control, and was seeking to identify champions in dignity and dementia care. They also planned to request volunteers to represent people's views in areas such as catering, staff recruitment, activities, cleaning, and health and safety.

There was a clear management structure. An organisation chart dated February 2015 showed the manager as "Group Manager", which meant they were also responsible for the provider's other home nearby, with a deputy manager, senior staff nurse / head of care and a home service manager. Day to day management was by staff nurses, team leaders and senior care workers. All the staff we spoke with were positive about the new arrangements and commented on improved staffing, training and support plans. One care worker said, "I can go to the manager if I have any problems. There is a suggestion box in the office we can put ideas in and staff meetings where we can raise concerns."

The manager and deputy manager made themselves available to people and staff every day. This was well received and commented on by a number of people and their relatives. The manager had an action plan for improving the service. It identified actions to be taken, who was responsible for them, when the action should be completed, and progress so far. They told us they were supported by the provider in making the changes they had identified.

The provider had systems in place to request feedback on the quality of service provided from people, their families and representatives, and from visiting service providers. Results from a quality survey undertaken in September 2014 showed most responses were positive, with eight out of 10 family members and 27 out of 32 people using the service giving the service a good or very good rating. Negative comments were to do with staffing levels and waiting times for assistance. The provider had taken steps to address concerns about staffing.

Positive comments included "caring, welcoming environment", "dignity matters", "care and attention is excellent" and "high standards".

There was a system of internal checks and audits in place to monitor the quality of service provided. The manager's audit timetable covered 17 areas and included checks on clinical governance, "resident dependency", medicines, "resident files", infection prevention and control, equipment, health and safety, cleaning and activities. In addition the manager made unannounced spot checks. In the week before our inspection they had made spot checks on the night shift.

We saw records of the most recent audits of infection prevention and control, clinical governance, wound care and resident dependency. There were no recent records filed for audits of moving and handling equipment, cleaning schedules, and activities although the audit frequency was recorded as monthly in the timetable. The manager had identified this in their service improvement action plan and had allocated audits to heads of department and senior nurses. Medicine audits had identified improvements concerning the storing and recording of medicines which had been carried out.

"Resident dependency" audits covered pre-admission assessments, care plans, risk assessments, monthly assessments for nutrition and pressure injury risks, consent and photograph. Changes in people's needs and circumstances were noted and carried over to their care

Good

Is the service well-led?

plan. For instance the audit had prompted a new capacity assessment for one person. The wound care audit showed actions taken in response to peoples' wounds and the involvement of outside healthcare services such as nurses specialising in skin care.

The infection prevention and control audit covered areas such as education and training, hand hygiene, personal protective equipment and laundry. The audit undertaken in January 2015 had identified a small number of areas for improvement. The service undertook an annual infection control statement, which was in line with Department of Health guidance on infection control in care homes.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care. Service users did not receive timely care that was appropriate, met their needs and reflected their preferences. Regulation 9 (1) (a), (b) and (c).