Springfield Manor UK Limited

Springfield Manor Nursing Home

Inspection report

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Ratings

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

Overall summary

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This was an unannounced inspection which took place over two days on the 28 October 2014 and the 4 November 2014. Springfield Manor Nursing Home is a privately owned care home for people who require long term and respite care, nursing, or palliative care for up to 30 older people some of whom were living with dementia. At the time of the inspection there were 23 people using the service.

There is a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

There were documents missing from recruitment files for some members of staff. This included one person references from their previous employer and professional registration for clinical staff. This meant that the provider could not be satisfied that only suitable staff were working at the service.

Some areas of Springfield Manor were clean including people's bedrooms and the living rooms. However the walls in the hallways were dirty and the reception toilet and chefs toilet were not clean. There were aspects to the infection control that needed improvement in relation to staff knowledge. There was a risk of cross contamination in the areas where the bed pans were cleaned and sterilised.

Staff did not have the appropriate knowledge of the Mental Capacity Act 2005 and they had not received any training. Where people were unable to consent and decisions were made about their care we could not find evidence of 'best interest' meetings.

Some people thought that staff were caring and they were treated with dignity and respect. Some also felt that if they needed privacy then this would be given. However, through our observations staff did not always take the time to communicate with people in a meaningful way.

People felt that staff understood their care needs. One person said that they felt very involved in the care and staff consulted them in every way. However we found that there were times when staff had not responded to people's needs specifically around those who had dementia. Not all staff understood the emotional and psychological needs of people with dementia. There were times where people were left for long periods of time without any interaction with staff.

Some activities were on offer and we saw board games being played with some people. However, there were few activities provided specific to the needs of individuals. One person told us that they were not asked what interests they had.

People understood how they could make a complaint and felt comfortable to do so. However, there was no system of recording and learning from complaints and how these were dealt with. There was a copy of the complaints procedure for everyone to see in the reception area.

People and their relatives told us that they felt they were safe at the service. All of the staff had received safeguarding adults training and had knowledge of the procedures and what to do if they suspected abuse.

There were enough staff to meet people's needs and people received personal care in a timely way. People's call bells were being answered quickly and there was always a member of staff around when needed.

There were processes in place in relation to the correct storage and audit of people's medicines. All of the medication was administered and disposed of in a safe way.

People thought the food was good and felt that their needs were catered for. People were encouraged to make their own decision about the food they wanted. We saw that there was a wide variety of fresh food and drinks available for people.

People had access to other health care professionals when required . The health care professionals said that people's clinical needs were being met by staff.

People, relatives and staff were not routinely asked for their opinion and feedback on what they thought of the service. We were told that this was done through one to one conversations. Some people completed surveys but these were not used to make improvements to the service where concerns had been identified.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

You can see what action we told the provider to take at the back of the full version of 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?

Requires Improvement

The service was not safe. Although people told us they felt safe good infection control was not always followed. There were some documents missing in the recruitment files for some members of staff.

Although the risk assessments for the clinical needs of people were undertaken these were not always done for people's emotional needs.

Staff understood what abuse was and knew how to report abuse if required. There were enough qualified and skilled staff at the home to meet people's needs.

All medicines were stored, administered and disposed of safely. Appropriate risk assessments were undertaken for people to reduce incidents and accidents.

Is the service effective?

Inadequate

The service was not effective. Staff did not have a good understanding of the Mental Capacity Act 2005 and were unable to evidence that peoples' right were being met. Staff did not understand about whether people were being deprived of their liberty.

Up to date training for both care and nursing staff was not provided.

People were supported to make choices and said that the food was good. People were helped to maintain their health and wellbeing and they saw doctors and other health professional when necessary

Is the service caring?

Inadequate

The service was not caring. We found that staff did not always provide the appropriate support and reassurance to people when it was needed.

People were not actively involved in the running of the service and were not always listened to.

Some people thought staff treated them with dignity and respect however we found that this was not always the case . We saw several examples of staff being kind and sensitive to people's needs.

Is the service responsive?

Inadequate

The service was not responsive. For people who could not communicate clearly not all staff understood their needs. There were not enough activities for people.

The provider did not actively seek the views of people to improve the service. Complaints were not recorded and there was no evidence that there was any learning from them.

Summary of findings

Is the service well-led?

The service was not well led. Appropriate audits around the service had not been done. Staffs understanding of infection control had not been monitored. Regular meetings were not taking place with people and staff in order that they could be involved in the running of the service.

People liked the manager and felt that they could talk to them about any concerns. Staff felt very supported and liked that they could be open and honest with the manager.

Inadequate

Springfield Manor 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.

During and after the inspection we spoke with seven people using the service, four relatives, the registered manager, nine care staff, one nurse, one cook, one activities coordinator, one laundry assistant and three health care professionals that visited the service. The professionals included a community Macmillan nurse, a physiotherapist and a community nurse.

The inspection team consisted of two inspectors and an expert by experience in dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at four care plans, 11 staff files and the medicines sheets for all of the people living at the service. We also looked at staff training records, audits of the home and general information displayed and records relating to the general management of the service. These included staff rotas and handover records. We carried out observations throughout the inspection. This included the lunch time meal, activities and interactions between staff and people. We spoke to relatives of people who were unable to communicate with us.

We reviewed records held by the CQC including notifications from the registered manager. For example where people had passed away or an incident at the service had occurred. We looked at information around a safeguarding incident that was reported to us by the registered manager.

We last inspected this service on the 27 November 2013 where no concerns were identified.

Is the service safe?

Our findings

People told us that they felt safe. One person said "I worry about how staff will manoeuvre my wheelchair but I feel completely safe when they are doing it." People felt that there were enough staff to assist them with their needs but that they were always busy.

Not all parts of the service were clean. The walls in the hallway were not clean and had dirty splash marks up them. The reception toilet and the staff toilet were dirty round the sink and the toilet bowl. Slings for use when hoisting people were hanging up outside a person's room, these were stained. This meant that there was risk of contamination. The registered manager was aware that not all aspects of the service were clean and told us that had been trying to recruit an additional cleaner. They told us that the service was too big for one person to clean and that they understood that more cleaners were needed to maintain good infection control.

Staff described to us how they would use the sluice rooms. They told us that they would wear gloves and an apron when placing the bedpans into the sluice machine and would remove the gloves and apron before leaving the room. However, they also told us that they would wash their hands after they left the room rather than use the sink that was in there. The registered manager said that staff should have been washing their hands before they left the room and was not aware that they were not doing this. There was no soap in the toilet off of the kitchen for staff to use to wash their hands. This meant that there was a risk of cross contamination.

Most staff had received infection control training. Staff had completed a 'Knowledge of Infection and Control Standard Precautions' questionnaire. Most of these had been completed in September 2014. Questions included how they would prevent the risk of infection. We saw from the completed questionnaires that answers had varied. For instance not all staff were aware of the importance of handwashing to prevent the spread of infection.The registered manager had not looked at the completed questionnaires and therefore no remedial action had been taken increasing the risk of cross infection.. This meant that there were not suitable arrangements in place to prevent and control infections. This was a breach regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at staff recruitment files to check that safe recruitment processes had been undertaken by the provider. There were gaps in the some of the files which included no references for one person that had previously worked in a care environment and no update nursing registrations for two members of staff. The provider told us that they do check for up to date registration but there was no evidence that this had been done. We were unable to look at files for all the members of staff as they were not kept at the service. This meant that the provider could not evidence that only suitable staff were working at the service. This was a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. After the inspection the provider confirmed that they had obtained the up to date registrations for all of the nurses.

Assessments were undertaken to identify risks to people. When clinical risks were identified appropriate management plans were developed to reduce the likelihood of them occurring. One person had a pressure sore on admission to the service and there were steps in place to address the risk of this deteriorating which included monitoring their weight. However, not all risks in relation to people's social and emotional needs were addressed. One care plan stated that '(the person) has mild confusion and is slightly forgetful' but there was no plan of how this needed to be addressed. Another person's care plan stated that the person wanted to go home and that they had recently had a diagnosis of 'Dementia'. The care plan stated that this person had anxiety and confusion but there was no information in the care plan to guide staff on how to reduce this. Without this guidance staff may not provide the most appropriate care for people. We raised this to the nurse on duty and the manger and they told us that they would address this. The registered manager told us that the staff had not had specific training in dementia but understood the need for staff to make sure that people's emotional needs were being met. They told us that they would start writing more information in the care plans to address people's emotional needs.

Some incidents and accidents at the service were recorded however there was no analysis or review of the accident or analysis of the trends and themes. There were no up to date records that showed where an incident had occurred what action had been taken reduce the risk of this happening again.

Is the service safe?

There were enough suitably skilled staff employed to keep people safe. The staffing ratio was developed based on the needs of the people who lived at the service. There were six care staff and one nurse on each shift and the rotas we saw showed that they always had the minimum staff required. When needed, the registered manager would call upon regularly used bank staff to cover for absences. This helped to ensure continuity of care for people. One bank staff member told us "The agency make sure that we are well trained and I have been here several times. For those residents that are new their needs are discussed at the staff handover." Health care professionals told us that they felt there were enough staff. Staff attended to peoples' needs in a timely way throughout the inspection. We saw throughout the day that people's call bells were answered in a timely way. People told us that they thought there were enough staff to meet their needs.

Staff had knowledge of safeguarding adults procedures and what to do if they suspected any type of abuse. One said "I have never seen abuse here but if I did then I would inform the manager and the nurse." They told us that they knew how to access the service policy on safeguarding and were aware that the Local Authority was the lead agency that dealt with safeguarding concerns. The registered manager has made us aware of any safeguarding concerns and has addressed these appropriately.

In the event of an emergency such as a fire each person had a personal evacuation plan and at each handover staff discussed these. The registered manager told us that in the event that the service had to shut it had been arranged they the nearest hospital would take people in. There were also action plans in relation to other emergencies including equipment failure and fire safety.

Controlled Drugs (CDs) were stored appropriately and audits of all medicines had taken place. We looked at the Medicines Administration Records (MAR) charts for people and found that administered medicines had been signed for. All medicines had been stored, administered and disposed of safely. There was a medicines policy for staff to refer to. In addition to this PRN medicine (this is medicine that is only given when needed) was given appropriately and recorded on the MAR chart.

Is the service effective?

Our findings

People told us that they felt their needs were being met and a health care professionals that we spoke with agreed.

CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). This aims to make sure that people are looked after in a way that does not inappropriately restrict their freedom. One member of staff told us that they were aware that one person, liberty was being deprived. They knew they should have applied to the Local Authority to establish whether this persons liberty had been appropiratly restricted but had failed to do so. They said that this person did not have the capacity to consent to having bed rails and there had not been a meeting with the persons representative to decide if it was in their best interest.

Most of the staff did not have any knowledge of the Mental Capacity Act 2005 (MCA) and the registered manager confirmed that no training had been provided. We saw that there was a 'Do not Resuscitate' form in one person's care plan and that they lacked capacity. There was no mental capacity assessments for them in the care plan so it was unclear how the manager or staff knew that this person lacked capacity. The registered manager told us that they had never undertaken mental capacity assessments for people and told us that they relied upon the local GP to do this. They said that they had never asked for any copies of these assessments but realised now that they should have done. The service had policies that referred to MCA for example 'Restraint' policy but staff did not have any knowledge of these. Suitable arrangements were not in place for obtaining, and acting in accordance with the consent of people. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us that they felt supported to undertake their role by their colleagues staffing team and the manager. They said that they had a handover when each new shift began and were able to have discussions about any concerns they had about the people who lived there. However, there was no system for staff to meet with their manager on a regular basis to have a one to one discussion. The manager told us that one to ones had not been arranged and annual appraisals were not taking place. This meant that staff did not have the opportunity to have a discussion with their manager about any concerns or training needs they may have had or their work to be assessed and apprasied. One member of staff told us who they reported to but added "I never see them, if I needed to speak to them I just would."

Training for staff was not up to date. The registered manager provided us with a training schedule that showed that a lot of the training for staff had been booked for the future. They were unable to provide us with the dates that most staff had last received training that was essential to work safely with people. for example 'Moving and Handling' had been booked for in the near future for all staff but it wasn't clear when this was last provided to them. The registered manager told us that they had purchased DVDs for training staff that related to 'Health & Safety', 'Infection Control' and other areas of training. They told us that they aimed to show these DVDs to all the staff over the next few weeks. Clinical staff were not up to date with the training specific to their role. There was no evidence to show when three nurses last received training in wound care, end of life care, blood taking and tissue viability care. The registered manager told us that they were aware that the clinical staff needed updated training and was looking into booking this. Arrangements were not in place for staff to receive the appropriate training, professional development, supervision and appraisals. This was a breach of regulation 23 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Where people had a diagnosis of dementia there was no evidence that the emotional needs of people were being met. We spoke to the registered manager about whether staff understood dementia. They told us that "We are not a dementia home, they (staff) know people." They told us that none of the staff had training in dementia but said that most of the people living at the home had some form of dementia. All of the staff told us that they didn't understand fully what different types of dementia there were. This meant that they could not provide appropriate care to people with a diagnosis of dementia.

Staff told us that they always gave people choices for example in relation to what they wanted to wear or what they wanted to do. One person told us "I would encourage people to make their own decisions." We saw several examples of staff giving people choices about what they wanted to eat and what they wanted to do. One person said they were offered choices with their food and drink.

Is the service effective?

People told us that the food at the service was good. Those people who had special dietary needs were accommodated for. One person who was at risk of choking, was provided pureed food. Another person did not eat meat and was offered an alternative meal each day. One person told us that they were supported to buy some of their own food that they particularly liked. There was a hot meal provided during the day and a lighter meal offered in the evening. The chef told us that if people wanted something different then they would provide this. In addition soup was offered every day. There was a range of desserts on offer and drinks were provided throughout the day. There was plenty of fresh fruit and vegetables with each meal.

Staff said that for those people who were at risk of malnutrition their food and drink intake was monitored. One said "I offer extra food if people want it, I like to make sure they have had enough." This meant that people were supported to maintain a balanced healthy diet. People were weighed regularly and for those that needed additional nutritional support this was provided by staff.

We saw examples where people had access to healthcare services. The local GP visited the service weekly. Other healthcare professionals such as the community MacMillan nurse, the community nurse and physiotherapist also visited the service regularly. They all told us that they felt that when they were called to the service that this had been done appropriately. The physiotherapist told us "I know people are happy, they are well cared for, I have always been impressed with the handover with nurses and that people are reassured, I don't have any problems whatsoever."

There was support in place from visiting health care professionals. Staff were able to speak with them when they visited the service. One health care professional told us that "I have no concerns (about staff abilities), it hasn't been an issue so far."

Is the service caring?

Our findings

People told us that staff were caring and respectful. One person said "I have relatives come to see me all the time, the carers are willing to listen, if you want to talk to them about something you could." A relative told us "The carers are pretty good."

There were occasions where staff were not caring. One person was sat at a table in the living room with a board game placed in front of them. This person was in a wheelchair and had been placed at a table with their back to everyone so they couldn't see staff or other people. The person was left there for approximately 30 minutes with no interaction from anyone despite there being staff around who could have offered support and reassurance. The person was clearly distressed and was asking for someone to help them. The person was ignored by staff for 30 minutes until a member of staff sat with them and the person became less anxious. We saw one member of staff sat with three people playing a game which they enjoyed. However there was another person who was sat at the table with a puzzle in front of them. We saw a member of staff stood next to the table doing the puzzle without any interaction with them. A member of staff was supporting someone else to eat their meal by standing next to them rather than sat with them. We spoke to the registered manager about these examples who said that this should not have happened. They told us that they encouraged staff to think about what it would be like if it was their loved one was being cared for in that way. However this was not evidenced in the actions we saw from the staff on the day. During our observations we saw some examples of staff being caring and attentive to people.

There were examples of people not being treated in a dignified way. People were sat in wheelchairs at the dinner table. the wheelchairs were not close enough to their tables meaning that some people were having to lean across to eat. This meant that food was dropping onto their laps as they were eating. The registered manager told us that they needed to get tables for wheelchairs to fit under more comfortably to avoid this from happening in the future and to maintain peoples independence to eat.

People told us that the staff treated them with dignity and gave them privacy when needed. Staff said they would cover people up before giving personal care and would knock on people's doors before entering. However, we saw occasions where they did not knock on doors before going into the room. The registered manager told us that they would speak to staff about this. When staff talked to people we saw that they did this in a respectful and kind way.

Staff told us that people's clothes were not ironed, they said that they would hang clothes once they had been washed to prevent creasing. They told us that that there was an iron there and if people wanted something ironed they would do this. One person told us that the laundry service was not very good and that "The ironing isn't done." We could see from what they were wearing that day that their clothes were not ironed. People were not treated with privacy and dignity. This is a breach of regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Is the service responsive?

Our findings

When we arrived at the service we found that people were sitting in the living room in wheelchairs positioned next to each other. There were no armchairs in the room for people to sit in and barely any furniture. The registered manager told us that some people chose to sit in their wheelchair all day but also said that there are not enough armchairs for people if they all chose to sit in one. One relative said that they were concerned that their family member had to sit in a wheelchair all day. We saw relatives had no space when they visited to sit with the family member without having to take them out of the room. One person said "I would like to sit in a chair, but staff can't use the hoist, it eases my bottom." A member of staff said that they didn't transfer people into chairs as there was not enough room for the hoist. The provider told us that "It had gone off my radar to get more chairs." On the second day of the inspection we saw that the living room had been re-arranged and that some people were now sat in armchairs. As a result people looked more comfortable and the room was more homely. However there still were not enough chairs for everyone to sit in and not everyone had been encouraged to sit in an armchair.

Each person had a full review of their care assessed by the nurse regularly. Risk assessments were undertaken regularly and looked at people's mobility, eating and drinking, weight and any health care needs. There was information for staff to help to reduce the risk of any concerns raised.

There was an activities coordinator employed at the service. They said that they provided activities two days a week and other days they said that staff undertook them. None of the staff had received any training in activities. The activities we saw were board games around the dining room table. The activities coordinator told us that "Activities are done as a whole, I have spoken to people about their preferences but I haven't recorded any of that. I haven't looked through people's care plans to see what their preferences are, we don't arrange any days out, families will arrange this." One person said "Im fed up with just sitting here" another told us "Not a lot of activities here, yesterday they had games but nothing around my interests." We did not see people undertaking meaningful tasks around the service. The registered manager told us that they would consider how they could include people more in the day to day running of the service. This meant that the staff were not always responding to peoples individual emotional needs. These are breaches of regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One person told us that if they wanted to make a complaint they would feel comfortable enough to do so. There was no recent system of recording and responding to complaints. The last recorded complaint was in 2008. The registered manager told us that they tended to deal with any complaints verbally. There was no system of recording what actions had been taken to resolve the complaint and no evidence of any learning from this. There was a copy of the complaints policy for people and visitors in the reception area. Staff told us that they would support people to make a complaint if needed

The registered manager told us that they didn't hold 'residents' meetings because people weren't fully engaging with them. There was no evidence to show how they were aware what people did and didn't like and how they learned from this. The provider told us that they had not undertaken any recent relatives meetings as they found that these were poorly attended. They said they tended to either speak to relatives on a one to one basis or when people's needs were being reviewed. One relative told us that when they did provide feedback they didn't feel this made any difference. There was no system of gaining feedback from relatives about the service and how it could be improved. This is a breach of regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff had an understanding of some people's needs but not all. The care plans had no background information on people's histories were. There was no person centred approach to their individual needs . One care plan stated that the persons interests included "watching telly, enjoys eating and doing activities." Staff were unable to tell us anything specific about this persons background. this was also the case for the other care plans we looked at . The registered manager recognised that they needed to do more to document people's backgrounds so that staff could have a better understanding of people. This meant that people were not getting all of their emotional needs

Is the service responsive?

met. They told us that they would address this with the staff. These are breaches of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
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Is the service well-led?

Our findings

People told us that they thought the registered manager was good. One person told us "She seems quite nice, quite open." We saw several examples of people and relatives approaching the manager in the office and around the service. However one relative told us that they did not feel listened to and that when they raised concerns with the manager they didn't feel it made any difference. The manager told us that staff were able to come to them whenever it was needed. Staff said that they felt they could go to the manager if needed. Health care professionals told us the manager was approachable and that communication was really good between them.

Although staff met at each handover there was no opportunity for all the staff to have a meeting together. The registered manager told us that staff meetings had not been taking place and that they knew they needed to address this. This meant that they didn't have the opportunity to discuss and share information and training with all staff, which would improve people's experiences.

The registered manager provided the CQC with necessary notifications in relation to the service. For example safeguarding referrals and where people had passed away. The registered manager told us that they wanted to improve the look of the service to make it 'more homely' but that resourcing was sometimes a problem. The provider told us that they were aware of the requests from the manager to improve the look of the home but had not addressed this as yet due to other commitments.

There were some systems in place to monitor the quality of the service. For example the registered manager would undertake spot checks of rooms to identify any areas of concern. These would then be raised with the care staff, maintenance or domestic staff. However, there were no recent audits in relation to people's care plans or the environment. The most recent environment check had identified that work needed to be done by August 2014 in relation to the maintenance to the building but it wasn't clear whether this had been checked. An audit of staffs clinical knowledge was undertaken in September 2014 in the form of a staff questionnaire. However, the questionnaires had not been checked to establish whether their knowledge was up to date and correct. The registered manager was aware that these still needed looking at. This meant that the registered manager and the provider didn't have systems in place to identify things that required improvement.

The activities coordinator undertook a survey with approximately six people. It was a tick box questionnaire and we saw where one person had identified a concern that had not been addressed despite the forms being completed weeks previously. There was no evidence to show how this was being used to improve the quality of the service as the questionnaires had not been checked by the provider or the registered manager. There was no clear management and governance of the service. These are a breach of regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was a statement of purpose to make it clear to people what type of service was provided. This also states that Springfield Manor has the capacity to meet the needs of people living with dementia. However this was not accurate as staff had not been trained and did not always understand people with dementia. It adds that people are invited to participate in the day to day organisation and running of Springfield Manor, offering choice and involvement in daily life. It states that people would also have the opportunity to go out on day trips. We did not see evidence of this during our inspection. This meant that the despite advertising that the provider could meet the needs of people with dementia staff had not been trained or equipped with the skills to do so.

There was a whistle blowing policy for staff and the registered manager told us that they would support any member of staff raising an issue. They said that one member of staff witnessed an incident and reported to the manager straight away for them to deal with. This meant that the registered manager supported the staff when they raised concerns.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person did not have effective systems in place to protect people from the risks of acquiring a health care associated infection as appropriate standards of cleanliness and hygiene were not maintained.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **People were not protected against the risks of inappropriate or unsafe care or treatment.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People were at risk of receiving inappropriate and unsafe care because the delivery of care did not meet their individual needs to ensure their safety and well-being.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The provider failed to ensure people were treated with dignity and respect**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The provider did not comply with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to information required in respect of persons seeking to carry on, manage or work for the purposes of carrying on a regulated activity.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The provider did not have appropriate arrangements in place to ensure that staff received a full induction or appropriate training.**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.