Tributary Ltd

Asquith Hall

Inspection report

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22 July 2021
27 July 2021
28 July 2021
29 July 2021
30 July 2021
11 August 2021

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Asquith Hall is a residential care home providing personal and nursing care for up to 53 people, some of whom are living with dementia and/or mental health needs. At the time of the inspection there were 48 people using the service. The service is purpose built with accommodation provided in two separate wings – Willow on the ground floor and Meadow upstairs. Each wing has its own facilities including lounge and dining areas.

People's experience of using this service and what we found
People were not always safe. People were at risk of harm as the provider had not identified, assessed or mitigated risks. This included risks related to people's health and care needs as well as environmental risks. Parts of the premises were not clean. Infection control procedures were not always followed by staff as personal protective equipment (PPE) was not worn correctly and social distancing was not maintained.

People did not always receive person-centred care and care records did not fully reflect their needs. People were not always treated with respect by staff or had their privacy and dignity maintained. Although some staff were kind, caring and compassionate and treated people well, other staff were task focussed and did not respond appropriately to people's needs. There were no activities taking place and there was little to occupy and interest people.

Staff did not receive the induction, training and support they needed for their roles. Staffing levels were sufficient to meet people's needs when all staff attended, however there were often last minute absences which impacted on staff numbers. We have made a recommendation about the management of staff sickness.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There had been a recent change in leadership and an ineffective governance structure meant the service was not appropriately monitored at manager or provider level.

People were supported to keep in touch with family and friends through video, phone calls and indoor visits. People had access to healthcare services. People's medicines were managed safely but guidance relating to pain management needed to improve. People were provided with a choice of food and drinks.

The manager and provider were responsive to the inspection findings, took action during and after the inspection and shared plans to improve their systems and processes.

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 the service under the previous provider was good, published on 2 December 2017.

Why we inspected
The inspection was prompted in part due to concerns about staffing levels and the high number of safeguarding notifications received which referred to restraint being used. A decision was made for us to inspect and examine those risks.

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 COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see all the sections of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, person-centred care, privacy and dignity and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Asquith Hall

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 was carried out by two inspectors, a medicines inspector, a specialist professional mental health nurse 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.

Service and service type
Asquith Hall 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.

The service did not have a manager registered with the Care Quality Commission. The registered manager left the service at the end of June 2021. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. An acting manager was in post when we inspected.

Notice of inspection
This inspection was announced. We announced the inspection from the car park shortly before going on site. This was because we needed to check the arrangements in place for preventing and containing transmission of COVID-19 prior to entering the building. Inspection activity started on 22 July 2021 and ended on 11 August 2021. We visited the service on 22 and 27 July 2021. The other dates were spent

reviewing information off site and making phone calls to people, relatives and staff.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority commissioners and safeguarding team and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection-
While on site we spent time with people in the communal areas observing the care and support provided by staff. We spoke with three people who used the service about their experience of the care provided and four relatives. We spoke with eight members of staff including the manager and nursing, housekeeping, catering and care staff.

Discussions with people who used the service, relatives and staff were conducted either on site or via telephone calls. We reviewed a range of records. This included seven people's care records and ten people's medicine records. We looked at two staff recruitment files. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people were not assessed and managed safely.
- Where risks had been identified, actions had not been taken to ensure people's safety. For example, sensor equipment put in place to mitigate the risks of falling, had often not been switched on. This meant staff were not aware when people had fallen.
- Staff were not following guidance to keep people safe. People's care plans stated they should be wearing appropriate footwear to help their mobility and reduce the risk of falls. Many had no footwear and wore only socks.
- People with limited mobility were not supported safely by staff to move and transfer from one chair to another. We observed four separate incidents where staff used unsafe moving and handling techniques.
- The environment was not always safe.
- The risk of falls from windows was not effectively managed. Many upstairs windows were fully open; although restrictors were built into the window frame these could be easily over-ridden. Additional restrictors had been installed on some windows but not all.
- Not all accidents and incidents were reported, investigated or dealt with appropriately. Some incident reports referred to management of actual or potential aggression (MAPA) holds being used on people but there was no detail of what type of holds were used or review to determine whether these restrictive interventions were appropriate in each situation. The provider had identified improvements were needed and was taking action to address this issue.
- Accident and incident analysis reports identified lessons to be learned and actions to be taken to prevent a recurrence. However, we found these actions had not always been implemented.

The lack of robust risk management processes meant people were not protected from harm or injury. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- We were not assured the provider was using PPE effectively and safely.

Staff were not wearing PPE correctly. We saw staff in the home without masks on, staff wearing masks below their noses and under their mouths, one person wore a cloth mask. Some staff wore jewellery which was not in accordance with the provider's uniform policy.

- We were not assured the provider was promoting safety through the layout and hygiene practices of the premises

Some parts of the building were not clean. Cleaning schedules were incomplete and did not evidence

regular cleaning. Hand sanitiser was not always available or used by staff.
● We were not assured the provider was meeting social distancing rules.
Social distancing was not always implemented. Staff were congregated together in communal areas and whilst on their break. Social distancing was not promoted by staff. We saw people sitting very close together in one lounge as the other lounge on the wing had been closed and could not be accessed.
● We were not assured the provider was making sure infection outbreaks can be effectively prevented or managed.

People were not protected from the risk of infection as control measures were not implemented consistently. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was accessing testing for people using the service and staff.
● We were assured the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment
● There were not always enough staff on duty to meet people's needs and keep them safe.
● A dependency tool was used to calculate safe staffing levels. Staff said these levels were sufficient if everyone turned up for their shift, but they said at times there were not enough staff due to last minute absences. This was confirmed by the duty rotas and the provider's own staffing audit.
● Staff were deployed to maintain a presence in certain areas of the home so they could observe people and ensure their safety. Staff said when numbers fell below the agreed levels, it became difficult to implement this system.

We recommend the provider reviews their management of staff sickness and absence.

● Recruitment checks including references and criminal record checks were completed before staff started working in the service. There were no interview records in the staff files we reviewed. The manager told us this would be addressed.

Using medicines safely
● Medicines were administered in a safe way
● Action was taken when medicine incidents were identified
● Medicines were stored safely
● Medicines that are controlled drugs were managed safely
● Guidance [protocols] on the use of medicines to be taken only when required were in place but did not contain any detail about pain management.

Systems and processes to safeguard people from the risk of abuse
● Systems were in place to protect people from the risk of abuse and harm.
●Staff had completed safeguarding training and understood their responsibility to report concerns.
● Where safeguarding incidents had occurred, referrals had been made to the local authority safeguarding team and notified to CQC.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
- Staff did not always receive the induction, training and support they required to fulfil their roles.
- Two new staff who had been employed for over two months had not completed induction training.
- Staff said they were kept up to date with online training. However, the training matrix and provider's training audit showed significant gaps in compliance. For example, less than 60% of staff had completed training in first aid, safeguarding and dementia care.
- Some staff said they had received supervision, others had not. The supervision matrix showed over 50% of staff had not received supervision in 2021.

Staff had not received the support, training and supervision necessary for them to carry out their roles. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
- People's nutritional needs were met.
- People said they enjoyed the food. A choice of meals were provided, with drinks and snacks available between meals.
- Specialist diets were catered for and fortified meals and drinks were provided to those who were nutritionally at risk.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
- Staff supported people to access the healthcare support they needed.
- Multi-disciplinary team meetings were held weekly with health care professionals to discuss and review people's care needs.
- People's care records confirmed the involvement of other professionals in providing care such as the mental health team, community matrons, GPs and the speech and language therapy (SALT) team.
- People also had access to the provider's own team of specialist clinical advisors including a nutritionist, physiotherapist and occupational therapist.

Adapting service, design, decoration to meet people's needs
- The service was purpose-built and provided spacious accommodation for people.

● People's bedrooms were comfortably furnished and personalised.
● Adaptations had been made to the environment to meet the needs of people living with dementia and promoted their independence. For example, bathrooms and toilets had pictorial signs. Bedroom doors were painted different colours and had people's names on to help them identify their rooms.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed before they moved into the service.
●The assessment was used to develop care plans and risk assessments.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Systems were in place to monitor DoLS applications and authorisations and to make sure conditions were met.
● Where people lacked the capacity to make their own choices and decisions, capacity assessments and best interest decisions were completed.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not always treated with kindness and compassion by staff.
- People's experiences varied. Some staff were very kind and caring providing comfort and support where needed. For example, a staff member was walking and chatting with one person encouraging them to have their hair done. The person was smiling. We saw the person later and they were pleased with their hair. We saw other staff sitting chatting with people and checking they were okay. One person told us how kind and understanding staff had been with them and described staff as 'marvellous'. Another person said staff were nice to them.
- However, we also observed staff who lacked warmth and empathy and were not responsive to people's needs, even when people were clearly distressed. Some staff only interacted with people when carrying out a task or to tell people not to do something.
- We saw how staff approach impacted on people's behaviour. A staff member approached one person who was asleep in a chair and without saying a word took off the person's slipper. The person awoke and was agitated and shouting. The staff member stopped, then went back and took the other slipper off, the person reacted in the same way and was left with one slipper off and the other on. A different staff member approached who spoke gently and patiently with the person who became calmer and the slippers were changed.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not always maintained and staff did not always treat people with respect.

- Some people looked unkempt; their hair was dishevelled and they had no footwear. One person's clothes showed they had been incontinent. It was over an hour before they were assisted to change even though staff had been interacting with them during this time.
- There was a lack of support for people at mealtimes. At lunchtime we saw one person sat in an armchair with a plate of food on their knee. They had no cutlery and the food had slid off the plate onto their lap and down their front. Staff were present but no one helped or supported the person. The person's care plan stated they preferred to eat in their bedroom but would eat in the lounge if sat at a table.
- In contrast, we saw a staff member who was gentle and patient when supporting a person with their meal, allowing them to eat in their own time and taking care to clean the person's hands and face when they had finished.

People were not treated by staff with compassion, dignity and respect. This was a breach of regulation 10

(Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
● People were involved in decisions about their care. We observed a staff member calmly explaining to a person why they needed to go to hospital and checking they understood and consented.
● Relatives told us they were kept informed. Care records had evidence that relatives were contacted about events, such as if a person had fallen or was unwell.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People did not always receive person-centred care.
- People's care records were inconsistent. Some contained personalised information about the care and support people required, others lacked detail and did not reflect the person's current needs.
- For example, one person's care plan made no reference to specialist advice provided by a nutritionist. Another person's care plan provided contradictory information about the person's mobility and the support they required.
- There was a lack of guidance for staff in how to support people who displayed distressed or aggressive behaviour towards staff during personal care. Care plans referred to staff using management of actual or potential aggression (MAPA) holds but gave no detail on the type of holds to be used or the circumstances when these should be implemented.
- People's care was not properly monitored. We found gaps in people's daily records. For example, one person who required support from staff with pressure relief and continence care had gaps of over five hours and nine hours where no care had been recorded.
- Some practices were not person-centred. For example, corridor watch where a staff member was allocated throughout the day to stand at the junction of two corridors to observe people walking around and intervene if necessary. Head counts were also carried out, where during the day staff recorded every hour where people were in the service and whether they were awake or asleep. At night this information was recorded two hourly.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's social care needs were not met.
- The provider employed three activity co-ordinators, however the manager advised only one was currently available.
- There were no activities taking place when we visited the service. We saw people spent their time walking up and down the corridors, in their bedrooms or sat in the communal areas.
- We saw some people enjoyed chatting with staff and staff accompanied others outside so they could smoke. Yet we also observed people sitting for long periods of time without any stimulation or interaction from staff. One person told us they were bored and said there was little to do.
- There were secure garden areas but these were not freely accessible to everyone. Keypad locks meant people could only access some areas with support from staff. One garden area was accessible to people on the ground floor. We saw one person attempted to go into this area but was prevented from doing so by staff who said there was no one to go with them.

● People were supported to keep in touch with family and friends. This included pre-arranged internal visits where government guidance was followed to keep people and their visitors safe.

People were not receiving person-centred care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's communication needs were met.
● Care plans provided information about people's communication needs.

Improving care quality in response to complaints or concerns
● Effective systems were in place to manage complaints.
● The manager confirmed no complaints had been received since December 2020.

End of life care and support
● Care plans were in place and recorded whether people had discussed their individual wishes and preferences in respect of end of life care or had declined to do so.
● Arrangements were in place for relatives to visit safely and spend time with people who were receiving end of life care.
● People had hospital passport forms which gave an overview of individual needs if emergency care was required.

Inadequate

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- Significant shortfalls were identified at this inspection. There were breaches in relation to risk management, infection prevention and control, person-centred care, dignity and respect. These issues had not been addressed through the provider's own governance systems.
- There had been a recent change in leadership and management of the service. The registered manager had left at the end of June and a new manager was in post when we inspected. Staff spoke highly of the manager and the improvements they were making. One staff member said, "It's starting to settle down now and improve with [name of manager]. You can raise things and [manager] listens and acts on it. That didn't happen before."
- The reporting and management of risks to people including accidents, incidents and falls was unreliable and inconsistent. The accident and incident analysis for April, May and June 2021 had been completed in July 2021. Repeated themes were identified which included sensor equipment not being switched on by staff. Although a new call monitoring system was now being installed, no action had been taken to address the issue previously.
- Quality audits were not effective in identifying issues and securing improvements. There was a lack of continuity and completion of the audit cycle in terms of actions identified and subsequent follow up.
- People did not always receive person-centred care that led to good outcomes for them. Care records were not always accurate or up to date.
- Provider oversight and monitoring was ineffective in identifying and managing organisational risk.
- Communication systems were not always effective in ensuring staff were kept informed of any changes and actions required. For example, handover records were not always available as staff had written over previous copies without saving a copy.
- Night staff said there were limited opportunities for them to attend meetings as these were usually held during the day. The manager confirmed there had been no night visit checks carried out in the past year.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and relatives expressed satisfaction with the care provided.
- Satisfaction surveys were completed in February 2021 by people, relatives and staff. A total of fifteen individuals were surveyed and the response rate was poor. Five people who used the service were contacted. Three were unable to respond, one did not understand the questions they were being asked and

the remaining person's answers raised some issues about sleep and care plans. There was nothing to show what action had been taken in response. Five staff were contacted, three did not respond, the other two gave positive feedback. All five relatives responded and gave positive feedback.
● There were limited opportunities for people to be involved and express their views and opinions about the service. No residents meetings had been held in the previous 12 months. The provider had decided to temporarily suspend residents meetings due to the pandemic. The manager had one planned for 26 August 2021.
● Staff said regular meetings were held and they could raise issues. Minutes showed the last staff meeting was held in May 2021 however this was restricted to heads of departments. The manager had a staff meeting planned for 12 August 2021.

We found systems to assess, monitor and improve the service were not sufficiently robust. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 manager understood the requirements of the regulations to make notifications and to comply with duty of candour responsibilities when things had gone wrong.

● Working in partnership with others
● The service worked closely with other agencies. Care records had evidence to show other professionals were involved in people's care.
● The manager and staff understood the importance and benefits of working alongside other professionals.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving appropriate care that meet their needs and reflected their preferences. Regulation 9 (1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receiving the training and support they required to meet people's needs and fulfil their roles. Regulation 18 (2)(a)

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider failed to ensure risks to people were assessed and as far as practicable mitigated. Risk of the spread of infection were not detected, prevented and controlled. Regulation 12 (1)(2)(a)(b)(c)(h)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to ensure effective systems were in place to assess, monitor and improve the quality and safety of the services; assess, monitor and mitigate the risks to people using the service and to maintain an accurate, complete and contemporaneous record of people's care and treatment. Regulation 17 (1)(2)(a)(b)(c)

The enforcement action we took:

Warning notice