Knights Care Limited

Drovers Call

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
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?	Requires Improvement

Overall summary

This inspection took place on 9 and 11 February 2015 and was unannounced.

Drovers Call provides care for older people who have mental and physical health needs including people living with dementia. It provides accommodation for up to 60 people who require personal and nursing care. Accommodation is provided in two units an upstairs and downstairs unit. At the time of our inspection there were 48 people living at the home.

At the time of our inspection there was a registered manager in post. The home had had three registered managers in the past year. The current manager had been in post since October 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

At the last inspection in August 2014, we found that the provider had not met the requirements for Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not protected against the risks associated with medicines because the provider had inappropriate arrangements in place to manage medicines. The provider told us what action they would take to make improvements however we found at this inspection that this action had not been completed and medicines were not managed appropriately.

People did not receive their medicines in a timely manner. We looked at eight of the 48 medicine administration record sheets (MARS) and found that people weren't getting their medicines as prescribed. We observed that medicines were not given in a safe manner to ensure that the dose given was taken.

Infection control risks were not consistently managed and people were at risk of infection.

On the day of our inspection we found that staff did not always interact in a positive manner with people.

People told us that they felt safe and well cared for. However we observed issues which caused us concern about people's safety and care. For example, the management and administration of medicines was inadequate. When we spoke with staff they were able to tell us about how to keep people safe however they were unclear about what to do if they needed to report concerns to outside agencies such as the local authority. In addition risk assessments were not always in place to ensure that people were cared for safely.

The provider acted in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA protects people who might not be able to make informed decisions on their own about their care or treatment. Where it is judged that a person lacks capacity, a person making a decision on their behalf must do this in their best interests. If the location is a care home the Care Quality Commission is required by law to monitor the operation of the DoLS, and to report on what we find.

We found that people's health care needs were assessed, however care was not always planned and delivered to meet those needs. There were gaps and inconsistencies in people's care records. People had access to other healthcare professionals such as a dietician and GP.

There were insufficient staff to meet people's needs appropriately. Staff did not always respond in a timely and appropriate manner to people. Staff were kind to people when they were providing support. Staff in the upstairs unit had a good understanding of people's needs.

During our inspection people did not have access to activities and excursions to local facilities. People experienced long periods of time without interaction from staff.

People did not always have their privacy and dignity considered.

People were supported to eat enough to keep them healthy. People had access to drinks during the day and had choices at mealtimes. Where people had special dietary requirements we saw that these were provided for.

Not all staff had received training to ensure that they had the skills to meet people's needs.

Staff told us that they did not always feel able to raise concerns and issues with management. We found relatives were clear about the process for raising concerns and were confident that they would be listened to. However, the complaints process was only available in written format and therefore not everyone was able to access this. Individual complaints had been resolved but some of the issues raised in complaints were still occurring because the manager had not put in place actions to address the issues which resulted in a complaint.

Accidents and incidents were recorded and reviewed to ensure trends and patterns were identified. The provider had informed us of incidents as part of our notification system.

Although audits were carried out on a regular basis and action plans put in place to address any concerns and issues they did not always identify issues of concern. For example, the recent infection control audit did not identify the issues raised at the inspection.

Summary of findings

We found a number of 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 this 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?

Inadequate

The service was not safe.

Staff were aware of internal arrangements to protect people from abuse. There were insufficient staff to keep people safe.

Medicines were not stored and administered safely.

Infection control arrangements did not protect people from risk of cross infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received appropriate training. A plan was in place to provide appropriate training.

People's nutritional needs were not always met. People had access to healthcare services.

The provider acted in accordance with the Mental Capacity Act 2005 (MCA).

Is the service caring?

Requires Improvement

The service was not consistently caring.

Care was not always provided in an appropriate and sensitive manner. Where people had difficulty communicating staff used non-verbal communication.

People were not always treated with dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Activities and leisure pursuits did not reflect people's personal preferences and experiences.

Care records had not been consistently reviewed and updated.

People and relatives were aware of how to make a complaint and raise

Is the service well-led?

Requires Improvement

The service was not consistently well led.

A process for quality review was in place. Audits did not identify issues raised in the inspection. Issues identified in complaints were still apparent.

Accidents and incidents were recorded and monitored.

Drovers Call

Detailed findings

Background to this inspection

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

This inspection took place on 9 and 11 February 2015 and was unannounced.

The inspection team consisted of an inspector, a specialist advisor in physical health care, a pharmacy advisor and an expert by experience. An expert by experience is a person who has experience of relevant care, for example, dementia care.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at notifications which we held about the organisation and information that had been sent to us by other agencies. Notifications are events which have happened in the service that the provider is required to tell us about.

After our inspection we contacted the local authority who pay for the care of some people living at the home to get their view on the quality of care provided by the service.

During our inspection we observed care and spoke with the registered manager, a nurse, three members of care staff, seven relatives and 10 people who used the service. We also looked at six care plans in detail and records of staff training, complaints, audits and medicines.

We used the short observational framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk to us. We carried out a SOFI in both units.

Inadequate

Is the service safe?

Our findings

At our previous inspection in September 2014 we found the provider did not administer medicines safely and there was a breach of Regulation 13. After our inspection the provider wrote to us to say what they would do to meet the legal requirements. At this inspection we found the provider to still be in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at medication administration records (MAR) for 12 of the forty eight service users on both units and covered nursing and residential service users. Eight of the records we looked at showed that people weren't getting their medicines as prescribed. We found that six people had been out of stock of one or more of their medicines for up to twenty days.

People didn't get their medicines as prescribed. Two people were regularly asleep at the time their medicines were due and therefore were not given it. There were no risk assessments or reference to this in their care plan of how to manage this or records of discussion with the GP as to the possibility of changing the time of the dose.

People weren't given their medicines in a way that ensured that the dose was taken. For example one person's MAR showed that their medicine was found at 6:45pm on their bedside table and had been there from the previous night. We observed the medicine round and saw the nurse prepare a soluble tablet in a medicine pot with water and give it to the resident before it had dissolved.

MARS were inaccurate and incomplete, for example, records did not show what dose had been given. The person was at risk of having an incorrect dose subsequently. Another two records did not consistently record people's allergy status and people were at risk of receiving inappropriate medicines.

On the second day of our inspection we observed the medicine trolley was left open, unattended or observed and was within the proximity of people who used the service who could have had access to the trolley and medicines. People were not protected against the risk associated with the inappropriate management of medicines. There was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager told us that they had recently recruited to their vacant posts and were in the process of carrying out recruitment checks. They said that when these staff members commenced at the home there would be more flexibility around covering the shifts for sickness. There was an arrangement in place to use agency staff if required however, the registered manager told us that it was often difficult to get agency staff and staff would often work additional hours, which meant that people were cared for by staff who were familiar with their needs.

Some people told us there were not enough staff. One relative said, "If they [staff] had more time they would be more attentive." Another relative said, "I sometimes can't find a carer to see to my [family member]. They say they are coming and then get diverted." They told us that they often ended up carrying out the support themselves which worried them as they weren't sure what happened when they were not there.

Another relative told us that they had observed a person requesting assistance for a twenty minute period before staff responded. They also told us that they had concerns about their relative getting help when they were not around.

We observed periods during the day in the downstairs unit when there were no staff available in the communal areas for people to get assistance. Three members of staff told us that they felt they were short of staff on occasions. One staff member told us that they felt there were insufficient nurses and senior carers available on a daily basis to provide support to staff. In the upstairs unit we observed a staff member was moved to the downstairs area because a member of staff had gone on escort with a person to hospital. This left only two care staff to support the people in this area. One member of staff told us that they felt that this was insufficient and that some people ended up not getting the support they required. The registered manager told us that there should usually be three carers on duty in the upstairs area plus a senior carer. They were unaware of the shortage in the upstairs area when we spoke with them.

There were insufficient staff to safeguard the health, safety and welfare of people. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was an unpleasant odour in some parts of the home and carpets and furniture were stained in both communal

Is the service safe?

and bedroom areas. A relative said that they felt their family member's room could be cleaner. The registered manager told us that they were in the process of reviewing cleaning procedures and monitoring.

We asked a member of the domestic staff how spillages would be dealt with, they explained that spillage kits were available. They told us that they would use the new carpet cleaner to suck up the spillage into the cleaner and then disinfect the floor/carpet with disinfector. We asked to see the carpet cleaner and found that it was a carpet washer of a type that was stated for domestic use only and would not be appropriate for this use.

Staff we spoke with told us that they were unsure of how to deal with spillages of body fluids and that they would ask a cleaner to undertake the process. They were also unable to explain what would happen if there were no cleaning staff on duty and did not know where spillage kits were stored. One staff member told us that they had not yet received infection control training. The Infection Control Policy that was given to us to review did not include information about how to deal with spillages of body fluids.

We saw that there were a number of cross infection risks for example, personal toiletries,used sponges and flannels were left in communal bathing areas. In addition we saw that light pulls in bathroom areas were not covered and equipment such as a commode seat and shower curtain were dirty. We asked about the frequency of washing the shower curtains and was told that they were taken down and washed if they were visibly soiled.

Hand gel dispensers were available throughout the home however, we observed in areas where people received personal care that the gel dispensers were empty. Hand gel is important for staff to use in order to reduce the risk of cross infection.

An infection control audit had taken place on the 2 February 2015 and areas for improvement had been identified. These included the fact that hand washing facilities were not all intact. This issue had not been included in the action plan that had been drawn up. An external audit had also been on the 17th June 2014 and action plans had been drawn up but there was no evidence of their completion or review. We saw evidence of a laundry audit that had been undertaken on the 2nd February 2015. This audit had noted areas of non-compliance as some staff had not received training in the Control of Substances Hazardous to Health. An action plan was in place to ensure these staff members had been provided with the required training.

Insufficient arrangements were in place to protect people against the risk of infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who used the service told us they felt safe living at the home. One person told us, "I feel very safe here …. They are all very good to me. and care for me"

Staff were aware of what steps they would take internally if they suspected that people were at risk of harm. However, they were unsure on how to report concerns to external agencies. They told us that they had received training to support them in keeping people safe. Staff said that information about safeguarding concerns were not fed back and that they were not kept informed of safeguarding issues. The provider had safeguarding policies and procedures in place to guide practice and we had evidence from our records that issues had been appropriately reported by the provider. The provider had a recruitment process in place which included carrying out checks and obtaining references before staff commenced employment. When we spoke with staff they told us that checks had been carried out before they started employment with the provider.

Individual risk assessments were not always completed for people who used the service. Staff were familiar with the risks but these were not always documented. For example, one person preferred their bedroom door locked at night however a risk assessment was not in place regarding this. Another person was recorded as frequently refusing medicines but a risk assessment had not been completed to identify how this could affect the person and what action staff should take to keep them safe. Where people used bed rails to keep them safe risk assessments were not always completed and it was not clear that the use of these was in people's best interest.

Accidents and incidents were recorded and investigated to prevent reoccurrence. For example, a record of falls was maintained and reviewed regularly by the registered manager.

Requires Improvement

Is the service effective?

Our findings

Staff told us they were happy with the training that they had received and that it ensured that they could provide appropriate care to people. They said that as part of the induction when they started employment with the provider they had received training and had a workbook to work through with support. Staff told us that they had received training in areas such as moving and handling, food hygiene and infection control. However there were still significant numbers of staff who had not completed training in some areas. In the PIR we saw that the provider reported a low uptake of training, in some areas less than 50% of staff had completed training. We saw a training plan was in place for the forthcoming year to address this.

People who used the service told us that they enjoyed the food at the home. One person we spoke with at lunchtime said, "The food is good."

A relative told us that their family member had a poor appetite and that the chef had, "Gone out of their way", to try and find things that they might like.

We observed staff in the downstairs unit asked people what they wanted for lunch during the morning, however, they did not have any prompts such as pictures to assist people with their choice. In the upstairs unit people were also asked what they wanted at lunchtime but in addition shown what was available.

When we spoke with staff they were able to tell us about people's likes and dislikes and any special requirements such as a soft diet. People had been assessed with regard to their nutritional needs and where appropriate plans of care had been put in place. We saw where people's needs had changed and they required additional support referrals had been made to the dietician for advice.

We observed in the downstairs unit that people did not have drinks available in the morning when we arrived at 10 am and had to wait for staff to come round and offer drinks at 10.30 am. One relative we spoke with told us that they were concerned their relative didn't get sufficient to drink because they had ended up in hospital with dehydration. They said, "Since then, I always get her drinks and make sure she has one before I leave… I come every day to see her". Another relative told us that they couldn't always access drinks.

We saw in the resident and relative survey that issues had been raised about the choice of food being limited. For example at lunchtime there was no choice for pudding however people who refused the pudding were offered an alternative such as a yoghurt or fruit. The registered manager told us that they would be discussing menus with people. This had already been discussed at a meeting with kitchen staff in February 2015.

People who used the service had access to local healthcare services and received on-going healthcare support from staff. The provider made appropriate referrals when required for advice and support for example, to the optician and chiropodist. A relative said, "The nurse from the surgery came only yesterday and checked her blood pressure etc. and that was marvellous… and the GP visits as and when – which is good" We spoke with a visiting professional who told us that they felt confident that staff followed their care plans.

Where people did not have the capacity to consent, the provider acted in accordance with

the Mental Capacity Act 2005 (MCA). The MCA protects people who might not be able to make informed decisions on their own about their care or treatment. Where it is judged that a person lacks capacity, a person making a decision on their behalf must do this in their best interests.

We looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of people using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are

trained to assess whether the restriction is needed. If the location is a care home, the Care Quality Commission is required by law to monitor the operation of the DoLS, and to report on what we find. At the time of our inspection one person was subject to a DoLS and another application had been made on another person's behalf.

Requires Improvement

Is the service caring?

Our findings

We had inconsistent views from people who used the service in both units and their families. Some people told us they were happy with the care and support they received. One person said, "The staff are always polite and courteous". Another said, "Some of the carers are lovely."

A relative told us, "They're very caring but short staffed." Another relative told us that there was a high turnover of staff and that it was difficult for residents, and relatives, to get to know each other well because of this.

Staff provided support and assistance to people however this was not always in a sensitive manner. We found that care was provided differently in the upstairs and downstairs units. For example, we observed in the downstairs unit a member of staff supporting a person at lunchtime. The member of staff did not converse with the person and stood over them when providing support rather than sitting at the person's level. Another person asked for a hot drink and was told to wait for the tea trolley. We observed the tea trolley arrived an hour after this request and people were not offered a choice of what they wanted to drink.

We saw that staff in the upstairs unit interacted in a positive manner with people. We observed they gave people choices about their care. For example, a member of staff asked a person where they would like to sit and what sort of chair they wanted to sit in. We saw that when they offered people snacks they explained what was available and also showed people in order to assist them with their choice.

In the upstairs unit we saw that people who were unable to verbally express their views appeared very comfortable with the staff who supported them. We saw staff responded to non-verbal communication when providing care to people. One person was distressed about being at the home and we observed a member of staff spend time reassuring them until they were happier in themselves. At lunchtime we observed a member of staff sit with a person outside the dining area to reassure and assist them as they did not want to enter the dining area.

When staff supported people to move they did so at their own pace and safely. However, we observed in the downstairs unit two occasions staff supported people to mobilise without explaining to them how to support themselves or what they were going to do to support them. We also observed staff talking across a person to each other rather than to the individual when they were assisting them.

Two relatives we spoke with told us that they didn't feel continence issues were addressed adequately. During our inspection we found that people were not offered assistance with their continence on a regular basis by care staff. We observed that people checked the seats on chairs before sitting down as they were concerned that they may be wet.

People who used the service told us that staff treated them well and respected their privacy. People told us and we observed that staff knocked on bedroom doors. We saw that staff addressed people by their preferred name and that this was recorded in the person's care record. Staff understood what privacy and dignity meant in relation to supporting people with personal care. However we observed a person was returned to the lounge area and required their hair brushing. Staff said they could not find the person's comb and instead used a comb from their pocket to comb the person's hair. The person was not treated with dignity and asked if they minded using another person's comb.

We also observed one occasion downstairs when staff did not speak discreetly to a person when responding to their request for support. The member of staff responded in a loud voice so that other people in the room were aware of the person's request for assistance.

Two relative's we spoke with told us that their relative's clothing regularly went missing and could not be located. They said that they bought 'nice' clothes but that they couldn't always find them when they visited.

People did not receive care that was appropriate to their needs. There was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Bedrooms had been personalised with people's belongings, to assist people to feel at home. The home was spacious and there were areas for people to spend time with their families if they wanted to, including the main lounges.

Requires Improvement

Is the service responsive?

Our findings

Relatives were encouraged to visit and support people. Relatives that we spoke with told us they visited the service regularly and found that staff welcomed them. Two of the relatives we spoke with told us that they had not been involved in developing their relative's care plan. We saw that their relatives lacked capacity and required support when making some decisions. One told us that they did not feel involved in their family members care and felt that communication was not always good.

We looked at care records for six people who used the service. Records detailed what choices people had made as part of their care and who had been involved in discussions about their care, for example, what time they liked to go to bed. One relative told us that their family member preferred to go to bed early despite medical advice and that staff supported them in their choice and minimised the risk to them.

We saw that care records had not been consistently reviewed and updated on a regular basis to ensure that they reflected the care and support people required. For example, one person had recently suffered a fracture and there was no mention of what care they subsequently required to support them. In another care plan we saw that a person had an allergy to a medicine but that this was not consistently documented throughout the care plan which meant the person was at risk of receiving inappropriate care.

We found in three other care records inaccurate recording in relation to risks, mobility and medicines. For example a person required two people to support them to mobilise. We observed that this was not provided and that the person mobilised freely. We spoke with staff about this and they told us that the person did not require this support however the care record had not been updated to reflect this. We found records were incomplete, for example, in one record changes to care had not been dated so it was not clear what the relevant care required was and in another body maps had been completed however the diagrams did not match the narrative in the records. This meant that wounds were recorded in the wrong place on the body map.

There was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were at risk of receiving inappropriate records because accurate records were not maintained.

During our inspection we did not observe people taking part in planned activities. People told us that they had previously been able to access activities for example, musical sessions and pampering sessions. When we looked in care records we saw evidence that people had participated in leisure pursuits such as visits by a school choir and bingo. In the upstairs unit we observed staff talking to people about their past life and experiences.

The registered manager told us that they were currently recruiting activities staff but that all the staff should be involved with activities. When we spoke with staff about this they told us that they did not have time to support people with their leisure pursuits'.

When we spoke with staff in the upstairs unit we found that they were able to tell us about people's individual needs and preferences. They told us about how they responded in order to meet people's needs. For example, one person liked to talk about their family and to support this they carried photographs around with them.

The complaints procedure was on display in the home in a written format. The complaints process was only available in written format and therefore not everyone was able to access this. Relatives told us that they would know how to complain if they needed to. A relative told us, "I would be able to speak to people if there were issues." Relatives told us that they had recently completed a satisfaction survey and that they were provided with an information leaflet about how to complain.

We saw that a recent complaint had been resolved satisfactorily. However although the registered manager kept a log of complaints some of the issues raised in complaints were still occurring.

Requires Improvement

Is the service well-led?

Our findings

The home had had three registered managers over the past year, the current manager had commenced in post in October 2014. The registered manager told us that they felt supported in their role and had access to appropriate resources and support when required. They said that the senior managers took time to ask how things were going. We observed that the registered manager had a good knowledge of the people who used the service and was able to tell us about people's needs. During our inspection the operational manager was visiting and they told us that they felt the changes in registered manager had made it difficult to consistently manage the service. However they said that they felt the registered manager was developing systems and processes to address this, for example they had started to have staff meetings again as they had not previously had these on a regular basis.

Staff said that they were aware of their roles and who to go to for assistance and support but did not feel that they were always listened to. They said that they would not always feel comfortable raising issues.

The relatives we spoke with told us that they would be happy to raise any concerns they had. They said that they would go to the registered manager. We saw a relatives' meeting had been arranged for the following week however two relatives we spoke with were unaware of this meeting. Surveys had been carried out with people and relatives. Two relative's we spoke with told us that they had completed a survey. We saw the survey had identified issues about the menus and the registered manager told us that they would be discussing this at the relatives meeting which was planned. Complaints had been raised about areas which we had identified during our inspection such as medicines and staffing however although the complaint had been resolved we found that these issues were still a problem.

The registered manager told us that they had been short of staff but had recently recruited to the vacant posts. They also told us that they were looking to rearrange the staffing arrangements to ensure that there were sufficient senior staff available to staff for support and advice. They said that staffing was arranged into separate teams so that people were cared for by a consistent team. However during our inspection we observed that staff were borrowed from the upstairs unit to support the downstairs unit due to shortage of staff. When we spoke with the manager about this they were unaware of the issues.

The provider had some systems and processes in place, for example the service had a whistleblowing policy and contact numbers to report issues were displayed in communal areas. Staff told us they knew how to raise concerns about any poor practices witnessed. Audits had been carried out on areas such as accidents and incidences, medicines and infection control and action plans were in place. However, these checks did not always identify the issues we found during our inspection. For example, an infection control audit had been carried out in February 2015 but this had not identified some of the concerns we found during our inspection.

Systems to assess and monitor the quality of the service provided to people were not effective. There was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **There was a breach of Regulation 9(1)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.** **People did not receive care that was appropriate to their needs.**

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 **There was a breach of Regulation 10(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Systems to assess and monitor the quality of the service provided to people were not effective.**

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 **There was a breach of regulation 12. Insufficient arrangements were in place to protect people against the risk of cross infection.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

This section is primarily information for the provider

Action we have told the provider to take

There was a breach of Regulation 20(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were at risk of receiving inappropriate records because accurate records 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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. There were insufficient staff to safeguard the health, safety and welfare of people.

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
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines There was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were not protected against the risk associated with the inappropriate management of medicines.

The enforcement action we took:
A warning notice was served on 6 March 2015. We have asked the provider to be compliant by 20 April 2015.