Rolamgold Limited

Adey Gardens Care Home

Inspection report

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Date of inspection visit:
25 November 2015
26 November 2015
03 December 2015

Date of publication:
16 February 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 25 and 26 November and 3 December 2015 and was unannounced. At the last inspection of this service in December 2014 the provider had breached a regulation relating to the prevention and control of infection. This was because the flooring in all except one bathroom and in shared toilets had exposed areas of concrete that could not be kept clean. We made a requirement notice about this. The provider wrote to us to say what they would do to meet legal requirements.

During the inspection in November 2015 we found the provider had taken no action to address these concerns. They had failed to replace the flooring to bathrooms or shared toilets. Bathrooms were in a poor state and one bathroom was very odorous. Clinical waste bins were sited near exposed concrete that could not be kept hygienically clean. Lifting equipment used by people (such as hoists) had a layer of debris on the legs and rust on the central column. Clean linen and bedding was stored on the floors in storage cupboards. The small kitchenette on the first floor was dirty and expired food was in the fridge. The laundry room was cluttered, with clothes trailing on the floor and damaged cupboards that could not be kept clean.

Adey Gardens is a two-storey purpose built home which is registered to provide care for up to 37 older people some of whom have nursing care needs. The first floor unit provides 12 places for people living with dementia. Some shared rooms had been converted to single occupancy so the total number of places in the home was 34. At the time of our inspection there were 24 people living at the home.

The home had a manager but they had not registered with the Commission and there had been no registered manager for over one year. 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.

There had been no routine checks of the safety of the premises, such as hot water temperature checks, since the end of July 2015. This meant the provider could not be sure that people's health and safety was being protected.

The service did not make sure people's rights under the Mental Capacity Act (MCA) 2005 were upheld. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'.

The provider had not made sure people were protected by deprivation of liberty safeguards (DoLS). This meant people were being unlawfully restricted because they were unable to leave the home without staff supervision.

Staff training did not include MCA or DoLS so staff were unaware of the impact of this or how to protect people's rights. The gaps in supervision records indicated that some staff had not received an individual

supervision session in the past year.

The care records about people were written in a personalised way but some records were incomplete and some guidance was missing. This meant people might receive care in an inconsistent way.

The provider had not made sure that required health and safety checks were carried out and any actions taken. The provider had not made sure the required six-monthly servicing of hoists and lifting equipment had taken place. This placed people at potential risk of harm.

The provider's quality monitoring processes were not effective in managing risk or making sure people received a safe service. Shortfalls had been identified at the last inspection but no remedial action had been taken.

People received good support with their health and the staff worked well with community and specialist health services. Visiting health and social care professionals told us the staff were knowledgeable about each person people and were aware of their individual preferences.

People who could express a view, and their relatives, felt the staff were caring and friendly. People described the care staff as "kind" and "helpful". Staff were caring and compassionate when supporting people. People were assisted in a way that promoted their dignity, and staff valued and respected them.

People and relatives had information about how to make a complaint. People and relatives felt the manager and staff were approachable and that the home had a friendly, welcoming atmosphere.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, they will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

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

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. Parts of the accommodation were in a poor state so could not be kept clean. This had been the case since the last inspection a year ago.

Routine checks had not been made of the premises so the accommodation may not have been safe for people.

People said staff attended to them in a timely way. New staff members were checked before they started work to make sure they were suitable.

Is the service effective?

Inadequate

The service was not effective. People were not protected from unlawful restrictions because the provider had not applied for deprivation of liberty safeguards (DoLS).

People's consent was not sought and decisions made on behalf of people had not been made in line with best interest were not asked

Staff did not have training in DoLS or mental capacity. There was no evidence that some staff had received regular supervision, although staff said they felt supported in their role.

Is the service caring?

Good

The service was caring. People and their relatives felt staff were kind and friendly. People were assisted in a caring way that upheld their privacy and dignity.

People's individual choices were respected and staff were knowledgeable about people's individual preferences. Staff asked people for their permission before supporting them.

Many of the staff had worked at the home for some years and had established good relationships with people and their relatives.

Is the service responsive?

Requires Improvement

The service was not always responsive. The care records of some people were incomplete so staff did not always have guidance to provide consistent support.

There were some opportunities for people to join in activities.

People and their relatives knew how to make a complaint and felt able to discuss any issues with staff.

Is the service well-led?

Inadequate

The service was not well-led. The provider had not made any of the required improvements in the past year.

The home had not had a registered manager for over a year.

The systems for checking the safety and quality of the service were ineffective or not in place, which placed people at risk.

Adey Gardens Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 started on 25 November 2015 and was unannounced. The inspection team consisted of an adult social care inspector, a specialist adviser 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. Further visits were carried out on 26 November 2015 by two adult social care inspectors and on 3 December 2015 by one adult social care inspector.

Before our inspection, we reviewed information about any incidents we held about the home. We contacted the commissioners of the relevant local authority and health authority as well as health and social care professionals to gain their views of the service provided at this home. We contacted the local Healthwatch to obtain their views. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with eight people living at the home and six relatives. We spoke with two visiting health care professionals, including a community nurse and a diabetes nurse. We also spoke with a director, the manager, deputy manager, one senior and four care workers, an activity staff member and a cook. We observed care and support in the communal areas and looked around the premises. We viewed a range of records about people's care and how the home was managed. These included the care records of six people, training records and quality monitoring reports.

Inadequate

Is the service safe?

Our findings

At the last inspection of this service in December 2014 the provider had breached a regulation relating to the prevention and control of infection. This was because the flooring in all except one bathroom, and also in shared toilets, had exposed areas of concrete where toilets had been previously moved. These areas of the floor were porous so could not be kept clean. We made a requirement notice about this. The provider sent us an action plan stating that bathroom floors would be replaced by 30 September 2015.

During the inspection in November 2015 we found the provider had taken no action to replace the bathroom flooring. Bathrooms were in a poor state with scuffed paintwork and one bathroom was very odorous. Clinical waste bins were sited on or near areas of exposed concrete flooring that could not be kept hygienically clean. Some lifting equipment used by people, such as a bath chair hoist, had a rusting central column which could not be properly cleaned and there was a layer of debris on the legs and a grubby seat.

Clean linen and bedding had been left on the floor in storage cupboards. The small kitchenette on the first floor was dirty. The laundry room was cluttered, with clothes trailing on the floor and had damaged cupboards that could not be kept clean. The provider did not ensure that the premises could provide a clean and hygienic environment for the people who lived there. This meant the provider had not done what they needed to do to make sure people who used the service and others were protected against the risks associated with control of infection.

This was a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection visit on 25 November 2015 we identified a significant hazard relating to the glass canopy at the entrance to the building. The timber frame of the canopy was rotten and some of the glass panels had slipped from position. This presented a potentially high risk to the health and safety of anyone entering or leaving the building. We wrote to the provider immediately about this matter. The manager wrote to us on 3 December 2015 to confirm that a glazing contractor had since risk assessed the canopy and arrangements were being made to remove it. The canopy was removed the following week.

The service employed a part-time maintenance staff member to carry out routine checks of the premises. However the staff member had been absent from the home since August 2015 and there was no evidence in the health and safety maintenance file that any routine assessment of the safety of the premises had been carried out since 28 July 2015. For example, the last record of checks of hot water temperatures was completed on 21 July 2015. Weekly checks of the call alarm, electrics, lights and fire log book had not been recorded since 28 July 2015. This meant potential risks to people living at the home were not checked or acted upon.

These matters were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they liked the home and felt safe there. Visitors told us they talked to staff when they visited and had no concerns about the safety of the service. One relative commented, "The staff here are excellent and look after my [family member]. They are caring and kind and I know she is ok."

The staff we spoke with were aware of safeguarding and stated they would know how to report any safeguarding concerns. Staff told us that they received training in safeguarding annually. They were able to recognise signs of potential abuse and knew what action to take. A member of staff stated, "I would go straight to the manager and report it." The staff we spoke with felt they would be listened to and were confident in reporting to the manager. There had been no safeguarding concerns about this service over the past year.

Risk assessments about people's individual needs were in place. The manager used a weekly review record to check risks relating to the care needs of people who lived there, such as pressure care, weight loss, hospital admissions and infections. This also included details of any falls and the action taken to minimise the risk of recurring falls, such as the use of sensor mats. Accidents and incidents were recorded and were analysed by the manager on a weekly basis.

There were individual personal evacuation plans for each person to show how staff should support them to vacate the premises in the event of an emergency. These were kept in an emergency file in reception so were accessible to all staff at any time. Fire drills had been held with staff five times over the past year so staff were familiar with these procedures.

People felt there were enough staff and they responded to requests in a timely way. One person told us, "Staff here are lovely and if I ring my call bell they come quickly." Call alarm bells were answered quickly during the inspection visits, although one visitor felt that call bells were not answered as quickly at weekends.

The staffing levels for the 16 people living on the ground floor nursing unit were one nurse and three care workers. The staffing levels for the eight people living on the first floor dementia care unit were one senior and one care worker until 2pm, then this reduced to one member of staff. This meant during the afternoon and evening there was one nurse and four care staff to support the 24 people. None of the current people on the first floor required two staff to support with mobility needs and staff told us that they could summon assistance from the ground floor staff by pressing a call bell.

At the time of this inspection staff told us there was a vacant nurse's post. The service aimed not to use agency staff, who would be unfamiliar with people's needs, unless it was critically necessary. At this time the manager, who was a registered general nurse, was carrying out three nursing shifts each week.

We looked at recruitment records for the three newest members of staff and spoke with them about their recruitment experience. The recruitment practices included applications, interviews and references from previous employers. The provider also checked with the Disclosure and Barring Service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people. This meant people were protected because the home had checks in place to make sure that staff were suitable to work with vulnerable people.

People got the right support with their medicines and at the right times. A medicines round was observed. People got their medicines at the right time and as they were prescribed. Staff checked to make sure the right medicines were being prepared. Staff explained to people what the medicines were and supported people to take their medicines, provided them with drinks, and made sure people were comfortable in

taking their medicines.

The staff member remained with each person to ensure they had swallowed their medicines. The staff member then signed the medication administration records (MARs), which made sure an accurate record was kept about the medicines people had taken. If the medicines were a variable dose, for example one or two paracetamol for pain, staff had not always recorded the number administered which would make auditing difficult.

Medicines were securely stored in a locked medicines trolley within a locked room. The drug refrigerator was located in the same room. Temperature records were available to show that staff recorded the temperature of the refrigerator along with the temperature of the medicine storage room on a daily basis.

Inadequate

Is the service effective?

Our findings

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

There were no records of people's consent to care and treatment, for example for photographs to be taken for medicines records. There were no mental capacity assessments even though staff told us that only one of the 24 people living there had capacity. Staff had not taken steps to complete 'best interest' decisions within a multidisciplinary team framework where decisions had been made that restricted people. For example for the use of bed rails for people with dementia who were unable to consent to this.

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

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

This service was not working within the principles of the MCA. Staff told us 23 people living there could not go out without staff supervision. We found that people were under constant supervision and were prevented from going out on their own. However none of the staff we spoke with could tell us how they ensured the home took action to make sure people were subject to the least restrictions.

People were restricted from leaving the premises without supervision so were deprived of their liberty. The MCA DoLS requires providers to submit applications to a 'supervisory body' for authority to do so to make sure this is in their best interests. However no assessments had been made of people's capacity and no applications had been made to the supervisory body. This meant the provider was failing to meet the requirements of deprivation of liberty safeguards, so people were being restricted unlawfully.

This is a breach of regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The staff training records did not include any reference to the Mental Capacity Act or DoLS. In discussion staff stated they had not had training in this area and were unclear about the impact of the MCA on the people who lived there. This meant the provider had not properly trained and prepared their staff in understanding the requirements of the Mental Capacity Act or the specific requirements of DoLS.

The arrangements for most mandatory training consisted of individual staff members watching a DVD and completing a questionnaire. The training topics included infection control, first aid, food safety, dementia

care and health and safety. The questionnaires were not dated so it was not possible to determine when the staff member had carried out the training. The manager was a trained trainer but they had not signed off the questionnaires as complete or correct. In this way it was not possible to determine whether the staff had gained sufficient knowledge from watching the training DVDs. For some staff members there was no evidence that they received role-specific training. For example, the training records indicated that a catering staff member had not completed training in food safety or infection control but had completed training in 'effective communication'.

We looked at how the provider supported individual staff through supervisions sessions. Supervision sessions allow individual staff members to discuss their professional development and any issues relating to the care of the people who lived there with their supervisor or manager. There were records to show that one group supervision session had been held in May 2015 to discuss infection control issues. However some staff had only received one other supervision in over a year. This was contrary to the provider's own supervision procedures. We could not find evidence of any supervision sessions for two nurses and one senior care staff member. The manager stated these had been carried out but not yet filed. We asked the manager to confirm the dates of the most recent supervision sessions for those staff members, however this information was not provided either during or after the inspection visit.

This was breach of regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The first floor unit provided accommodation for people living with dementia. There were no items of visual and tactile interest for people around this unit, such as themed areas and reminiscence artefacts. There were few visual signs to help people recognise different areas or rooms. There were no picture menus to help people make choices about their meals. This meant the home did not have specific design features that supported people living with dementia.

People were complimentary about the quality of the meals. One person commented, "The food here is good and I get a choice. It is always hot and there are good portions." Another person told us, "The food here is very good and the cook will do you anything you want."

Relatives also commented positively on the food and the support with meals. One relative told us, "They make sure she eats and keep me updated." Some people needed full assistance with their meal and some people were poorly in bed so staff assisted them individually in their rooms. This was carried out in a sensitive and unhurried way at the person's own pace.

The chef was knowledgeable about each person's dietary needs. He described how he made smoothies and fortified foods for people who needed "building up". There was a list in the kitchen of the people who needed thickened drinks and different textured foods. Where people were identified as being at risk of poor nutrition staff completed daily 'food and fluid balance' charts.

The nurses and care staff liaised with dietitians and specialist nurses to support people's nutritional well-being. For example, one person received their food via a tube directly into their stomach (called PEG feeding) and also had diabetes. The home staff worked with the diabetes nurse and PEG nurse to get the right feeding regime for the person to make sure they received the right nutritional input.

People's records showed details of appointments with and visits by healthcare and social care professionals. We saw evidence that staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed, for example GPs and dieticians.

A visiting health care professional told us there was always a nurse on duty who brought them the information they needed during their visits to a patient. They told us, "The staff are very approachable and communicate well with me. They use the appropriate equipment and techniques."

The home was part of a local community health care scheme, called the Coalfield Initiative. The initiative aimed to improve primary care and nursing care in care homes and to reduce admissions and readmissions to urgent care. As part of the scheme a community nurse from the local GP practice liaised with the home to check people's health care needs. This helped to ensure people received timely support with any changes in their health, which could also help to prevent some admissions to hospital.

Good

Is the service caring?

Our findings

People and their visitors made many positive comments about the "caring" and "friendly" staff. For example, one person stated, "I am content here. The staff are nice and helpful." A relative commented, "Staff are great, there is a good choice of food and my [family member] is bathed regularly."

Staff were caring and compassionate when supporting people. One staff member was seen speaking slowly and respectfully when assisting a person to eat and drink, giving reassurance and explaining actions before offering support in a dignified manner.

We noticed that staff knocked on bedroom doors and respected people's privacy. Staff told us they felt it was important to treat people with respect. We overheard one member of staff saying to one lady, "Would you like me to do your hair before your husband comes in and you will feel better". The person smiled and agreed with this.

All the visitors commented on how people were supported with their personal appearance and this supported people's dignity. For example one relative commented, "Staff are very nice and ensure [my family member] is always clean and tidy." Throughout the visits staff asked people if they would like a bath or if they wanted something to drink.

During the inspection we observed staff working with people in a patient and sensitive manner. There were affectionate interactions and humour was used appropriately. We saw staff were patient when supporting people. For instance, one person had quite agitated behaviours and throughout the day members of staff would spend time sitting and talking with them and holding their hand.

Staff did encourage people to be as independent as possible. For example encouraging them to eat by themselves but offering support discreetly. One staff member who worked on the dementia unit told us, "I love my job here. We understand people and we read their expressions and interpret their needs when they cannot communicate with us."

Relatives told us staff were very good at informing them how their family member had been and they appreciated this. For example, one visitor stated, "Every time I come into the home staff update me on what has been happening." Another relative told us, "The staff look after my [family member] and always keep me up to date." We also saw examples of this. For instance,
as one relative entered the home a staff member told them, "Your [family member] refused breakfast this morning. She has asked for some toast so it is on it's way". The visitor looked really pleased with this.

There were several relatives visiting during this inspection. They told us they could visit at any time and were always made welcome. It was clear from discussions with visitors that there were good relationships and communication between staff and relatives. A staff member told us, "It feels like a family with the people who live here, we all get on."

Health care professionals also commented positively on the interaction between staff and the people they supported. One visiting community nurse told us, "There's always a nice atmosphere here because staff seem friendly and willing to help people. Staff have a caring attitude."

Requires Improvement

Is the service responsive?

Our findings

The service used a computer-based care recording system called 'caresys'. There was only one computer in the home, which was in the manager's office. This meant staff working on the first floor would have to call for staff from the ground floor to relieve them whenever they needed to record something on the computer downstairs. A visiting healthcare professional was also concerned that the computerised care system was not accessible at all times. They told us, "There is the potential for gaps in notes if staff can't access the computer, and if care professionals can't leave the information on the person's care file because it's on-line."

Care plans were person centred and gave a picture of the person and what their needs were. However the quality of care recording was variable. Some people's care records were detailed and regularly reviewed. Others were difficult to navigate and incomplete. Assessments had been carried out which showed people were at risk of developing pressure ulcers. However, for one person who had significant needs in this area we found their care plan to be blank. A staff member told us that they had completed the assessment, body map and care plan but that it had "disappeared" from the computer. This meant there was not a detailed care plan to instruct staff what action they should take to maintain skin integrity, so the person may be receiving inappropriate care and treatment. We noted that moving and turning charts were in use to monitor people's care in this area; however they did not state the specific timings of positional changes and the frequency of positional changes were not consistently completed.

There were daily 'food and fluid balance' charts for some people but we saw that these had been inconsistently completed. For example in three of the six people's records we viewed there were several days' gaps in those records. There was no intake targets recorded on the fluid charts to show whether the goal had been achieved. There were no portion sizes on food intake records and half of the records we viewed had not been completed after 4pm.

Some people needed 'as and when required' medicines, for example for pain or agitation. However there were no specific support plans about when these medicines should be given. This meant staff had no guidance to make a consistent judgement about when to support people with those medicines.

This was a breach of regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People relatives and care professionals felt the care service was personalised and the staff responded to any changes in individual needs. It was clear from discussions with staff that they were knowledgeable and empathetic about each person's individual needs. For example, one nurse described how a person with short term memory would often start a meal but rarely finish it. So the staff knew to help reintroduce the meal as a "little and often" approach so the person got sufficient to eat over the course of the day.

A visiting health care professional commented, "I've observed how the care staff listen to the nurses and they act on what the nurses instruct them to do. The staff follow my advice and if they have any queries they

contact me to check and get guidance which means they are very pro-active."

We saw staff chatted with people as they went about their work. Staff adjusted their support and communication style to meet the individual needs of people. During the first visit there was little positive social interaction or stimulation for people. The activities organiser was on holiday and there were no other arrangements for activities during their absence. One visitor stated, "Nothing much happens here in the way of activities." People on both floors were sat in the lounge in front of the television throughout the day, but no-one was engaged or watching the television programmes. On the first floor there were no magazines, books or rummage boxes for the people living with dementia.

During the last visit the activities organiser was on duty and was able to describe a number of regular activities. These included taking one person at a time on a weekly trip to a shopping centre. There were about eight people who went out on the shopping trips, so they had the chance every eight weeks to do this. Other activities included crafts, bingo, exercises, manicures, films and music. The activities organiser also spent some time reading stories and chatting to individual people who were bedfast.

People and their relatives said they knew how to make a comment or raise a concern. They said the staff were approachable and they felt able to discuss any issues with them. None of the people or visitors we spoke with said they had had cause to raise a complaint. Staff relationships with visitors seemed very good with good communication and humour.

The manager confirmed people were given an information pack (called a service user guide) which included details of how to make a complaint. This information was a little out of date because of changes to contact details. The manager had kept a record of previous complaints but none had been reported since the last inspection.

Inadequate

Is the service well-led?

Our findings

There had not been a registered manager at this home for over a year since October 2014. There was a manager who had been in post since that time but they had not applied for registration with CQC. The provider had failed to make sure that the conditions of registration were being met and we are dealing with this outside of the inspection process.

The manager was rostered as a nurse for three days a week, which meant they were only carrying out the role of manager on two days a week. The provider was a limited company. A director of the company said they regularly visited the home, sometimes on a weekly basis. At this time there was no written record to demonstrate the outcome of the provider's visits.

Notifications about changes, events or incidents are required to be submitted to CQC. We saw from care records that two people had sustained serious injuries over the past year as a result of falls. The staff had taken appropriate action to ensure these were treated. However the provider had not made sure that the statutory notifications were submitted to the CCQ in relation to those incidents. This is a failure to notify and we are dealing with this outside of the inspection process.

Infection control audits were carried out on a three-monthly basis by the deputy manager. However, the audits did not identify the continuing concerns regarding the exposed flooring in bathrooms and toilets; therefore the audit tool was unsuitable.

There were baths and en-suite showers at the home that were not in use. The audit tool included the question 'There is evidence that baths, showers and sinks taken out of use have planned provision for running water weekly (check maintenance records)'. but there was no record in the maintenance file that any checks had been carried out to run the water from these facilities. However the audit tool had scored this action as met. This meant the audit process was incorrect and ineffective, and did not match our findings relating to the continuing failures in infection control and prevention.

There was a continuing breach of regulation relating to the control of infection in the home. The provider's action plan, received in July 2015, stated that all bathroom floors would be replaced by 30 September 2015. However we found this had not taken place and there was no indication of when this might be addressed. This meant there had been no action by the provider to ensure that improvements were made to the safety and quality of the service for the people who used it.

There was no evidence in the health and safety maintenance file that any routine or preventative checks of the premises had been carried out since 28 July 2015. This meant the provider had not monitored the health and safety of people who used the service, so there was not a robust and effective system in place to ensure risks to the premises were assessed or managed.

Many of the people living at the home had mobility needs which meant they needed to use lifting equipment such as hoists. Lifting equipment has to be checked every six months to make sure it is still safe for use

under Lifting Operations and Lifting Equipment Regulations (LOLER) 1998. There were records of LOLER servicing dated 13 January 2015 in the home but none existed for July 2015. The manager stated the servicing was carried out by a contractor and confirmed it should have been done in July 2015. When asked, the manager stated that the provider still had a contract with the contractor to carry out the LOLER checks. However we found that there was no longer a contract in place for checks of lifting equipment. This meant the provider placed people at potential risk of harm as the equipment was not being checked for safety in line with legislation.

In these ways the provider had not operated effective systems to assess and monitor the quality of the service provided and identify, assess and manage risks relating to the health, welfare and safety of people who used its service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

People told us they liked the manager and the staff. People and their visitors said they felt able to discuss any matters with staff. The activities organiser described how she had attempted to hold resident/relatives' meetings but these were not well attended. At the last meeting in May 2015 only two relatives had turned up.

Some of the visitors we spoke with felt they had not been asked to give their views in a survey. However the results of a questionnaire compiled in May 2015 were on the noticeboard in the entrance for people to read. The results did not show the number of people who had taken part, but did reflect mainly positive responses except in relation to the home's décor.

The atmosphere in the home was calm and relaxed. Staff seemed happy in their work and several had worked in the home for quite a few years. Staff said they felt supported in their work by the manager and the nurses. One staff member commented that the manager was approachable and had acted when issues had been raised.

Staff meetings were held and there had been three full team meetings over the past year. This meant staff had an opportunity to contribute to the running of the home and to discuss key information and expected standards. For example, at the meetings staff had been informed of the new 'Care Certificate' training and had been asked their views about the introduction of nutritional records.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Records in respect of people using the service were not always complete so there was a risk they may receive inconsistent or inappropriate care. 9(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014 Need for consent The provider was not acting in accordance with the Mental Capacity Act 2005 and did not ensure care and treatment was provided with the consent of a relevant person. 11(1) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that staff received appropriate training or supervision to enable to carry out their role. 18(2)(a)