Four Winds Care Limited

Admiral Court Care Home

Inspection report

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Date of inspection visit: 15 April and 6 May 2015
Date of publication: 06/08/2015

Ratings

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

Overall summary

We inspected Admiral Court Care Home on 15 April and 6 May 2015. This was an unannounced inspection which meant that staff and provider did not know that we would be visiting.We visited in order to check the actions the provider had taken to safeguard people who lived at the home.

We had inspected Admiral Court Care Home in December 2014 and issued formal warnings in respect to the provider failing to meet the following regulations:

• Regulation 13: Management of medicines, as staff were failing to ensure people were protected against the risks associated with the unsafe use and management of medicines.

• Regulation 15: Safety and suitability of premises, as the service was failing to ensure people at its property were protected against the risks associated with unsafe or unsuitable premises.

• Regulation 22: Staffing, as the service was failing to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed at the home.On 3, 4, 8 and 15 March 2015 we

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inspected Admiral Court care home to determine what improvements had been made. We found the home had made no improvements and were breaching all 16 of the regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

These were all of the regulations from 9 to 26. Also there were failures to meet the requirements of regulations 11, 12 and 18 of the Care Quality Commission (Registration) Regulation 2009. The care was so poor that we judged the home as failing to meet every aspect of the CQC assessment framework and rated it as inadequate.

We had serious concerns about the service provided at the home and took urgent action to prevent any admissions to the home. This led to a condition being imposed on the provider's registration to that effect.Admiral Court Care Home is a large purpose built home registered to provide nursing care. The home has the capacity to take up to 50 residents.

Admiral Court Care Home is registered to care for older people, people living with mental health disorder and/or dementia as well as people with sensory impairments. On 6 May 2015 there were 23 residents living there, 12 upstairs and 11 downstairs.

Since the last inspection the registered manager who had been in place since 1 December 2014 has resigned and no registered manager is in post. 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. A manager from one of the provider's other services was working at the home.

We were told by placing authorities that in general families remained content for their relatives to remain at the home.

At this inspection we saw that where relatives had raised concerns with the standard of care the manager acknowledged the legitimacy of these concerns and gave assurances that action was being taken to make improvements. They also outlined to families that this may take some time to achieve. Relatives that we spoke with felt the staff were more caring and the manager was actively trying to make improvements.

We found that little had changed. Although some minor improvements were noted we found that the provider continued to breach all 16 of the regulations relating to care in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These were all of the regulations 9 to 26. Also there were failures to meet the requirements of regulations 11, 12 and 18 of the Care Quality Commission (Registration) Regulation 2009. Despite us making the provider aware of these failings following the last inspection and the need to make notifications these breaches of the Care Quality Commission (Registration) Regulation 2009 continued.

We also found that the provider failed to recognise when they needed to make safeguarding referrals. We found that the manager did not follow the provider's disciplinary procedures so failed to take action in line with the home's policy and dismiss staff when they were found to be asleep on duty. We also noted the manager had not received a copy of the new certificate from the provider and was unaware that we had imposed a condition to prevent admissions to the home.

Alongside these breaches we found although some of the staff tried to provide good care the provider had not supported staff and ensured they understood the need to provide basic care such as drinks and food when people asked for this or appeared thirsty.

We found that care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare. Although some action had been taken to write new care plans these remained inadequate to meet people's nursing needs.

Staff continued to remain unaware of the current people's conditions, needs and their risk profiles and were not able to demonstrate how they meet people's needs. Care staff told us they did not know why people were at the home and felt it was not appropriate for them to look at the care records. Therefore they could not outline how to support people, particularly those with mental health needs.

We found that the provider had a disregard for people's humanity and the Human Rights Act 1998, particularly Article 5, the right to liberty, and Article 14 prohibition of discrimination. We found that staff failed to adhere to the five principles of the Mental Capacity Act 2005 and were

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imposing restrictions upon people although staff had not assured themselves that people did lack capacity to make decisions. We found that people were unlawfully detained at the home.

We saw that the provider did not have adequate systems in place to protect service users from abuse caused by acts of omission and neglect.

We saw that staff continued to fail to ensure people who remained in bed had access to ample fluids and saw that some people's water was not provided fresh each day. We started the inspection at 5.30am and saw that one person had a half full beaker of blackcurrant juice dated 4 May 2015. The person told us that staff had kindly given them a drink of that juice and throughout the day we saw this was not refilled but the level of fluid gradually reduced. People were not protected from the risks of inadequate nutrition and dehydration.

We found that staff were still not taking action to minimise presenting risks associated with immobility, choking and poor nutrition/hydration. Staff failed to ensure service users received appropriate medical care for wound care, deterioration in health conditions and the monitoring of potential adverse effects of their medication.

We found that people were still not protected against the risks associated with medicines because the provider had not ensured appropriate arrangements were in place to manage medicines.

Staff did not ensure suitable arrangements were in place to protect service users against the inappropriate use of physical intervention.

We found that where people had requested to challenge the decision to subject them to a deprivation of liberty authorisation staff took no action to ensure they were supported to contact the Court of Protection and appeal this decision. Staff also took no action to ensure people had advocates where needed or when people told them they wanted to move from the home that their social worker was contacted so their care could be reviewed and a move facilitated.

The home is not registered to accept people with a physical disability or learning disabilities. Although since the last inspection some of the people with physical disabilities had moved elsewhere people who required adapted wheelchairs remained at the home, as did people with learning disabilities.

There was a walk-in shower room on the first floor which was large enough for people with mobility needs. The passenger lift is too small to accommodate the adapted wheelchairs people used, which meant they could not use this facility. Since the last inspection a shower table had been provided to one ground floor bathroom but the two people with significant physical disabilities were still to be assessed to see if they would be able to use this facility. This meant that these people had still not been able to have a bath or shower.

None of the shared toilets were designed for people with physical disabilities and did not have any equipment, such as grab rails, to support people with reduced mobility.

Staff failed to protect people from avoidable harm and despite us highlighting on 3, 4, 8 and 15 March 2015 the risks associated with completing the refurbishment work whilst people lived in the area they took no action to reduce this risk until a person was injured at the end of March 2015.

We found that the provider had continued to take no action to address the unsatisfactory elements identified on the electrical installation condition report issued in November 2014. We were provided with two new fire installation certificates but the forms indicated that these were completed by electricians registered with the regulating bodies for electrical contractors. The certificates were for the work completed during the refurbishment and not a full review of the safety of the overall wiring. We noted on one of the certificates one of the faults identified as low risk was identified by a competent electrician as dangerous and requiring urgent action.

We found some works had been completed to address matters raised in the Regulatory Reform (Fire Safety) Order 2005 issued 8 January 2015 and the recommendations from 23 February 2015 Hartlepool Borough Council fire risk assessment. However, night staff still could not tell us how many people were living in the

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home or locate the Personal Emergency Evacuation Plans. The newly appointed night nurse was not clear about the fire procedures although they assured us they had received a thorough induction.

We found that since the last inspection the provider had ensured the passenger lift complied with Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). One of the baths had not been serviced at the required interval in January 2015 and had not been decommissioned. The manager stated this was because it required a new battery to be fitted. There was no signage to instruct staff not to attempt to use this equipment. We highlighted this to the manager and they put a sign in place.

We found that the provider continued to fail to have adequate systems in place to assess and monitor the quality of the service that was being provided. They had not taken action to ensure they were assured that the building was safe and that satisfactory checks of the building were in place. The manager had put new templates in place for some aspects of the service but these were either not completed or inadequately completed. The provider continued to fail to meet the needs of the people who used the service.

We found that the provider did not operate effective recruitment procedures. Although evidence was now available to show checks had been completed, when Disclosure and Barring Service clearance (DBS) or references highlighted previous convictions or that people had been dismissed from other services the provider did not undertake further checks; take action to risk assess the impact this might have; or reduce the risk. Since the last inspection staff had been appointed although these concerns were evident and following the provider obtaining DBS for the other staff no action had been taken to reduce any associated risks when convictions were highlighted.

There were not sufficient numbers of suitably qualified, skilled and experienced staff employed to provide the care that people required. Staff had not received appropriate professional development and had not been suitably trained. No competency checks had been completed for the nurses and the manager told us this was not necessary because they were nurses so accountable for their own practice. This is untrue as the provider is accountable for ensuring all of the staff working in their services are competent to deliver the care being provided.

We found that the agency nurses who worked at the home were still not provided with suitable or detailed information about the people's conditions, primary needs and current nursing needs. We also found that people were not protected against the risks of unsafe or inappropriate care because the care records were not accurate.

We found that the ambient temperatures within the home remained in excess of 25°c and the provider continued to take no action to resolve this or ensure it did not adversely impact the that adequate cleaning and infection control prevention were maintained.

We found there were multiple of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Following the last inspection we issued a notice of decision which imposed a condition that prevents the provider admitting people to Admiral Court Care Home.

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

We found that people who used the service and others had not been safe.

Staff had not met people's needs or ensured risks to people from the environment were reduced or minimised.

There were insufficient suitably qualified and experienced staff employed to meet people's needs. Recruitment procedures were in place but failed to ensure people were protected.

Medication was not handled, stored and administered appropriately.

Is the service effective?

Inadequate 

We found that service was ineffective.

Staff did not have the skills, knowledge and experience to provide care to the meet the needs of the people who used the service. The provider had scheduled training but this was not in place and much of the essential training staff needed was not scheduled to happen until later in the year.

The requirements of the Mental Capacity Act 2005 and the Mental Health Act 1983 (amended 2007) were not met. Some people's lifestyles were restricted unacceptably and without due regard to their rights.

The catering staff were not appropriately trained and staff did not ensure people received a healthy balanced diet and adequate amounts of fluids.

Is the service caring?

Inadequate 

We found that the service was not caring.

Staff were very caring but lacked the skills and knowledge needed to ensure they developed therapeutic relationships.

The service was not designed in a way that would promote people's independence and autonomy.

Is the service responsive?

Inadequate 

The service was not responsive.

People did not receive personalised care that was responsive to their needs.

People were not engaged in any meaningful activities and staff continued to observe people from doorways and nursing stations.

When people raised concerns, staff did not recognise them as complaints or identify allegations of abuse so did not pass to the appropriate authorities.

Staff used discriminatory and derogatory terms when recording people's views in the care records.

Summary of findings

When people said they wanted to leave the home staff took no action to facilitate the move. No action had been taken to ensure that people had access to advocates when appropriate.

Is the service well-led?

Inadequate 

The service was not well led.

The provider did not monitor or assess the service and had not ensured that people who used the service were safe, received effective, caring and responsive services which met their needs.

Staff had not been supported to ensure the way they worked empowered people to live as independent life as possible.

Staff were observed to continue to disregard any views expressed by the people who used the service.

Admiral Court 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 took place on 15 April and 6 May 2015 and was unannounced.

The inspection team consisted on the first day of two inspectors, a pharmacist inspector and an expert by experience who spent the day at the home. On the second day the team consisted of five adult social care inspectors who commenced the inspection at 5.30 am and spent the full day at the home.

The provider was not asked to complete 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. However they had sent us information to suggest they were compliant with all the Health and Social Care Act 2008 regulations.

Before our inspection, we reviewed the information we held about the home and information from meetings held with the local authority commissioners and the Clinical Commission Group (CCG). We also contacted the local GP practices and pharmacists that were involved with the home.

Over the course of two days the team observed the care being provided throughout the home. We spoke with 13 people who used the service, six relatives, the provider's power of attorney, an acting manager who was still employed as a registered manager at another service, the administrator, the clinical lead nurse, a nurse, a senior care worker, 12 care staff, the cook, assistant cook and a domestic staff member.

We also reviewed 12 sets of care records, the medication records and seven staff records as well as management information such as infection control audits.

Inadequate

Is the service safe?

Our findings

During the inspection of Admiral Court in December 2014 we had issued a formal warning in respect of the maintenance of the building; administration of medication; and employment of sufficient suitably qualified and experience staff. The provider sent us information to show how they were addressing these issues and assured us they would be compliant by February 2015. In March 2015 we inspected and found that these concerns had not been addressed. We also identified additional and significant concerns with a service.

In light of the level of our concern we took enforcement action and a new certificate of registration was issued that imposed a condition preventing admissions to Admiral Court Care Home was issued. We also made the provider aware of our significant concerns and that we have judged these findings to have a major impact. The provider responded and informed us that action had been taken to ensure the home now met regulatory requirements

At this inspection we found the provider had failed to achieve compliance and remained in breach of regulations identified in March 2015.

At the last inspection we found that the provider had commenced major refurbishment work on the top floor but had taken no action to reduce the impact this had upon people who resided on that floor. They had not moved people to a safer environment whilst the work was completed or put measures in place to ensure people were not living in the area whilst the building work was underway. Despite us on 3, 4, 8 and 15 March 2015 highlighting this significant failing to the provider, staff continued to fail to protect people from avoidable harm. Staff took no action to reduce the risks associated with completing the refurbishment work whilst people lived in the area until a person was injured at the end of March 2015. Following this accident the provider took action to ensure the route the workmen took to enter and leave the home avoided contact with people. It is unacceptable that someone needed to be harmed prior to them recognising this risk.

We found that the provider had taken no action to address the unsatisfactory elements identified as C2 (Potentially dangerous – Urgent remedial action required) on the electrical installation condition report issued in November 2014. We were provided with two new fire installation certificates but the forms indicated that these were completed by electricians registered with NICEIC or NAPIT (which are the regulating bodies for electrical contractors). The certificates were for the work completed during the refurbishment and not a full review of that safety of the overall wiring. We noted on one of the certificates three unsatisfactory elements identified as C3 (Recommended – remedial action required) however we found one of the faults was identified by a competent electrician as a C1 (Dangerous – urgent action required).

We found that some works had been completed to address matters raised in the Regulatory Reform (Fire Safety) Order 2005 issued 8 January 2015 and the recommendations made in the Hartlepool Borough Council fire risk assessment dated 23 February 2015. However, night staff still could not tell us how many people were living in the home or locate the Personal Emergency Evacuation Plans. The newly appointed night nurse was not clear about the fire procedures although they assured us they had received a thorough induction.

Since the last inspection a new carpet had been fitted to the corridor on the first floor unit and the corridor walls had been painted. Some bedrooms on both floors had been fitted with new carpets. However bedrooms on the ground floor had scuffed, marked walls and some had exposed areas of plaster and water stained ceilings. There were areas of peeling wallpaper in a lounge.

In some shared toilets the toilet seats were loose which presented a risk of falls to people. The water pipe to the washbasin in a ground floor toilet was leaking and this could present a slipping hazard.

The temperature of the first floor unit was 28°C. On the ground floor the temperature averaged 26°C. This made the accommodation uncomfortably hot for people who used the service.

The bedrooms on the ground floor had had unsuitable yale-type locks removed but no other type of lock had been fitted yet. This meant unoccupied rooms were accessible by anyone. One vacant room was being used to store redundant furniture and this could present a tripping hazard if people entered this room accidentally. A former

Inadequate

Is the service safe?

'nurse clinic' next to the dining room had an oxygen tank and other items lying on the floor. This room was unlocked and could present a potential hazard to people if they went in by mistake.

The design of the home was not compliant with that expected for service for people with physical disabilities as the corridors and doorframes were too narrow; the largest bedrooms were on $12m^2$; and the passenger lift was too small to accommodate adapted wheelchairs or to allow paramedics to take people to an ambulance on a trolley. People with physical disabilities continued to live at the home despite this being raised at the March 2015 inspection.

This was a continued breach of Regulation 15 (Safety and suitability of the premises) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found medication practices remained unsafe and continued to be managed in the same way as reported on in December 2014.

The system for obtaining, handling and administering medication remained disorganised and we found a number of people had not received their medication. We observed the clinical lead nurse administered the medication from the blister packs but they did not check each label. We questioned their technique, as it leads to the risk of misadministration of medication. We asked them why they did not use of dot and pot method, which is a simple method that has been shown to prevent staff inadvertently administering the wrong medication, they had not heard of this technique. We explained how to use the method. The clinical lead nurse agreed it was a good way to improve practices and went on to administer medicines to another person then realised they had not used the dot and pot method and asked us to explain it again.

We also saw that medicines were being crushed and administered altogether in fluids. The clinical lead nurse was unaware of the need to check with the pharmacist that it was safe to crush and administer medicines; that crushed medicines should not be mixed together; or that putting them all into a flavoured drink could be seen as covert administration (hidden in foods so the person would not know). They were unaware that convert administration cannot be undertaken without any authorisation being sought to do this from the multi-disciplinary team. We found medicines had at times run out such as Olanzapine and several days went by before these were in stock.

The clinical lead nurse also failed to use a no touch technique, which meant they handled all of the tablets with their bare hands. They were unaware of the risks to themselves associated with the failure to adhere to this requirement and handled Finasteride (which is for prostate cancer), which is absorbed through the skin and can be harmful to those touching it.

When the clinical lead started preparing one person's medicines, they said the individual never takes their Adcal D3, but the clinical lead nurse still put it in the pot with other medicines. We asked why the person did not want to take it they said the person said it hurts their stomach. None of this was recorded, staff had not contacted the GP to make them aware this medicine was not being taking; discuss the concern the person had raised; and to see if there was an alternative.

We found that staff had not received any Zoplicone and none was in stock but recorded that they had administered three doses of this medicine.

We found that staff were not identifying that the pharmacy was unaware that people had allergies to medicines such as Beta Blockers and penicillin. No checks were in place to make sure healthcare professionals were alerted to these allergies and staff had not recorded it in the information people would take to hospital.

Medicines were not managed safely for people and records had not been completed correctly. Medicines were not obtained, administered and recorded properly.

This was a continued breach of Regulation 13 (Management of medicines) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found levels of competent staff being employed at Admiral Court remained unsafe. We found that the registered manager who was a nurse had left. The clinical lead nurse had not untaken any competency checks and the acting manager (who is not a nurse) did not feel that competency checks of nurses were needed. The acting manager felt nurses were accountable for their own

conduct and competency. This is untrue and from our observations the clinical lead nurse needed retraining around safe handling and administration of medicines as well as how to address people's physical health needed.

The acting manager was not a nurse but they and a senior care worker were writing the care plans for nursing clients, which related to their mental health disorders, their capacity and behaviour. We found these plans were inappropriate and failed to appropriately support people with their mental health needs. We found the language used could be discriminatory and derogatory. We found that where physical health nursing needs were identified no care plans were in place.

A recent safeguarding alert had found that the staff had failed to identify when one person had developed wounds, which had resulted in these becoming severely infected. This had the potential to be dangerous and also it was found that the staff had taken no action to reduce the contractures people developed although these could be reduced. At this inspection we found that the nursing staff had not taken action to ensure a further person did not develop sores and we saw that these became infected before any action was taken.

We found that the nurse and four care staff on night duty were unclear about how many people were living at the home and did not know where the evacuation plans were kept. They could not tell us which people were able to leave the home independently and who would need support. Also they were unclear about what to do to support the people who used adapted wheelchairs to leave the home.

At the time of the inspection we found that one nurse and four care staff were on duty overnight but were told by staff that this was highly unusual. From a review of the staff rota we found that two days a week there would be four care staff on duty overnight but the rest of the time there were three staff. During the day we found two people had one-to-one support so had dedicated staff. For the remaining 21 people a nurse, senior care worker and four care staff were on duty.

The evacuation plan we found and reviewed stipulated that in the event of a fire two staff would support each immobile service users. We noted that six staff would be needed to undertake this task. This meant overnight they would be insufficient staff to safely evacuate the building and during the day the registered manager, one administrator and three ancillary staff would be required to support the remaining 16 people, some of whom had limited mobility.

We noted that people's files showed they were displaying a range of current and significant risks such as violence, poor gag reflex with a high risk of choking and restricted movement. Staff who were working in the home continued to have a limited understanding of what these risks meant for their practice or how to use the information in assessments. We found that the care staff had not been provided with any support to develop the skills needed to complete appropriate risk assessments around these types of behaviours and conditions.

This was a continued breach of Regulation 22 (Staffing), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that although it was raised in March 2015 no action had been taken to review the statement of purpose or the service user bands. The provider's statement of purpose and service user guide stated that the home was suitable for people who had lived with mental health disorders; dementia; and/or sensory impairments. We found that the provider had not requested to amend the service user bands to add they could accommodate people with physical disability or a learning disability yet people with these conditions remained at the home.

These are continued failures to meet the requirements of regulations 11 and 12 of the Care Quality Commission (Registration) Regulation 2009.

We again found that the care staff we spoke with could clearly detail when people were admitted to the home; what care needs they had; their current condition and how they were to be supported. We found that although this was repeatedly asked for in March 2015 staff had taken no action to provide agency staff with information about people's presenting needs and their existing conditions. Agency staff were still expected to look through care records to find this information. These care records remained incomplete, inaccurate and at times

uninformative. We found that staff failed to ensure people's needs were assessed and care was planned and delivered in ways that would ensure service users were protected from inappropriate or unsafe care.

This was a continued breach of Regulation 9 (Care and welfare) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that since the last inspection action was taken to make referrals to external healthcare professionals however, this was initiated by the visiting community matrons. We found that for example a referral had been made to the dieticians but when these staff attempted to contact the home for further information they could not get through and had to write to the home instead. We saw that these professional took telephone information about a person's condition and weight, which staff provided. However, at closer review this person had chosen not to be weighed on a number of occasions and the date given for their last weight they still had not been weighed so it was unclear where the data given to the dietician came from.

We saw records from consultants making complaints about the quality of information they were receiving from staff attending appointments. One consultant stated, "I would be grateful if you could ensure this gentleman gets regular three monthly Prostap injections as the information we get from the carer is grossly inadequate and patchy during his recent clinic visits" and "He was accompanied by a carer who did not know anything about this patients care."

Also we saw that people had been diagnosed with other healthcare conditions such as cancer but the new diagnosis were not written in any of the individual care records.

This was a continued breach of Regulation 24 (Cooperating with other providers) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the provider continued to fail to notify the safeguarding team and us of a number of incidents, which were safeguarding matters such as the injury one person received, episodes of assaultive behaviour, medication omissions and staff being asleep on duty.

This is a continued failure to meet the requirements of regulations 18 of the Care Quality Commission (Registration) Regulation 2009.

We found that the acting manager and staff failed to recognise when incidents or allegations would be considered to be abuse and therefore need referring to the local safeguarding team. We found that staff still did not know how to raise safeguarding alerts.

There had been occasions when the police should have been called but were not, for instance when allegations of wilful neglect were made or people had physically assaulted others. Neither had these been reported to the LA safeguarding team or us.

At the last inspection people told us they felt frightened of staff. Staff confirmed that they had also been told this as did the registered manager but they had not recognised this as a safeguarding concern. When we raised this with the manager they dismissed it as a part of the individual's mental health condition. Nothing in these people's care records suggested that they had mental health conditions that would lead to them making false allegations. Therefore no action had been taken to report the matter, investigate the concerns or mitigate the risk.

We raised a number of safeguarding alerts with the local authority during the inspection in March 2015.

Despite having raised these matters we saw that further concerns had been raised by people who used the service about the practices of staff and that these people had independently contacted the police. Staff had dismissed the allegations made and stated in the care record comments like "does not like being told no" and "will cut off their nose off to spite their face." In response to the calls being made to the police staff had prevented the people having access to a telephone.

We again raised a number of safeguarding alerts with the local authority following the inspection

The high temperatures in the home remained a concern. During the visit the temperatures remained excessive. We again saw that in communal areas no jugs of water or drinks were available so no-one had access to drinks unless staff provided it. Throughout the visit the only drinks made available were at the discretion of the staff. We found that people were perceptibly thirsty and gulped down drinks when these were offered. We found that staff did not make

sure people were not at risk of dehydrating nor were they taking action to make sure people did not overheat or dehydrate. This is an act of omission and therefore a form of abuse.

This was a continued breach of Regulation 11 (Safeguarding service users from abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that since the last inspection the provider ensured the passenger lift complied with Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). But one of the baths had not been serviced at the required interval in January 2015 and had not been decommissioned. The acting manager stated this was because it required a new battery to be fitted. There was no signage to instruct staff not to attempt to use this equipment. We highlighted this to the acting manager and they put a sign in place.

Again we found that the nurse call alarms in bedroom were not located in a position that was accessible for the people or where not in place. Although on 15 March 2015 we saw that action had been taken to make sure most call alarms were accessible this had not been monitored and in the majority of bedrooms the nurse call alarms could not be reached. For the people who could not use nurse call alarms no other means of raising the alarm were accessible to them such as pressure mats and they were unable to call for help.

This was a continued breach of Regulation 16 (1), (2) and (3) (Safety, availability and suitability of equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the records of all of the staff to check that the home's recruitment procedure was effective and safe. We found that since the last inspection action had been taken to check staff suitability to work with vulnerable adults. However, the provider had got staff to bring in old Criminal Records Bureau (CRB) checks (such as ones from 2009), which significantly pre-dated their employment with them; accepted out of date Disclosure and Barring Service clearance (DBS) for newly employed staff or took no action when DBS showed a person had convictions including those for grievous bodily harm. DBS checks show whether people have been convicted of an offence or barred from working with vulnerable adults.

We found that staff who did not have a valid CRB/DBS check were working unsupervised at Admiral Court Care Home. We saw that one newly recruited staff members reference suggested they had been dismissed for sleeping on duty. We found no action had been taken to explore the validity of this claim and the person was employed in a senior position on nights. We found that the manager had found that some staff had been sleeping on duty but despite the provider's policy stating this would lead to instant dismissal the staff were still working at the home.

We again reviewed documentation in relation to the registration of nurses employed by the service. We found it did not hold information for all current staff. Staff again had not obtained information to confirm that they had current Nursing and Midwifery Council (NMC) registrations. We made the manager aware of this and the administrative staff completed the relevant checks whilst we were there.

This was a continued breach of Regulation 21 (a), (b) and (c) (Requirements relating to workers) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection some improvements had been made to support hygiene and cleanliness in the home. For example, new boxing had been provided to toilets and bathrooms so that these surfaces were now cleanable. The sluice room had also been cleaned. In most areas of the home odour control was good, although there were two bedrooms that had an unpleasant odour even though one of these was unoccupied. Staff stated the rooms had been 'deep cleaned', however the odour persisted and it was anticipated that new flooring would be the only solution. The domestic staff had now taken responsibility for checking and cleaning mattresses each week and this was recorded on the cleaning schedule.

However there were no effective measures in place to manage the risk of infection. There was a designated infection control lead who was responsible for checking

Inadequate

Is the service safe?

and addressing infection prevention and control practices in the home. This included regular reviews of staff practices in hand hygiene. However the hand hygiene practices of only nine of the 49 staff members had been reviewed.

The provider had infection prevention and control procedures for staff to follow, which were dated January 2015. However, only eight of the 49 staff members had signed to show they had read them.

The acting manager told us the provider was unable to demonstrate whether staff members had previously received training in infection control and prevention because the previous provider had not supplied that information. Training for all staff in infection control had been arranged for the end of May 2015.

Some equipment in the premises was in a condition that made it difficult to keep clean, and this compromised the control of infection of the people who lived there. For example, the light pull cord to a well-used toilet was dirty, and there was brown grime around the base of one toilet pedestal. The bases of two bath chairs were badly rusting and these would be immersed in the bath water with people who used these facilities.

Protective equipment and hand sanitisers were available throughout the home. However an open box of protective gloves was being stored on a handrail in the main corridor outside the manager's office where people walked. This compromised the dignity of the people as well as, potentially, the hygiene of the gloves.

This was a continued breach of Regulation 12 (Cleanliness and infection control), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said, "It is like a prison in here." And "I do like some of the staff, they do try hard to help."

Inadequate

Is the service effective?

Our findings

At the inspection in March 2015 we identified significant concerns with the service and found they continued to fail to meet the Health and Social Care Act 2008, (Regulated Activities) Regulations 2010. We found staff there were insufficient suitably qualified staff working; there was insufficient tables and chairs to allow people to use communal areas; guidance issued by professional and expert bodies was not put in place; staff were not applying the principles of the Mental Capacity Act 2005 or appropriately seeking Deprivation of Liberty Safeguard authorisations; people were not treated with respect; their nutritional needs were not met and there was no access to any meaningful activity.

In light of the level of our concern we took enforcement action and a new certificate of registration was issued that imposed a condition preventing admissions Admiral Court Care Home was issued. We also made the provider aware of our significant concerns and that we have judged these findings to have a major impact. The provider responded and informed us that action had been taken to ensure the home now met regulatory requirements.

At this inspection we found the provider had failed to achieve compliance and remained in breach of regulations identified in March 2015.

At the last inspection a nurse identified themselves as the clinical lead and told us they had been in post seven weeks and was a registered nurse for people with learning disabilities. This nurse has now left and we were introduced to a different person who claimed to have been the clinical lead nurse at the home for the last few years. No explanation was provided as to why we were not alerted to the inaccuracy of the previous staff member's assertions although we directly discussed them and their behaviour at the inspection in March 2015.

At this inspection we continued to find that there was no evidence to show that the provider had checked if the agency nurse and permanent nurses had the competencies required for working with service users at Admiral Court Care Home. We found that the permanent nursing staff lacked the skills and competencies to deliver effective care for the people who used the service. The new night nurse was unfamiliar with people's needs and had to rely on care staff to tell them what people needed. The clinical lead nurse had failed to ensure the care records accurately reflected people's needs; identify and address in a timely manner deteriorations in people's physical health needs; failed to take appropriate action to make safeguarding alerts; and could not administer medicines in a safe manner. The inspection team found that the nursing staff lacked the skills and competencies to ensure people safely received the care they needed.

This was a continued breach of Regulation 22 (Staffing), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that significant gaps remained in all identified training needs and significant concerns remained in respect of lack of staff training. For example in the March 2015 inspection we highlighted that 10 of the then 61 staff had completed food hygiene. At this inspection we found in response to our concerns about food hygiene training no additional staff had completed the training and the sessions that had been booked were scheduled for July 2015. We found that moving and handling staff had been undertaken but eight staff including the clinical nurse lead did not attend any of the sessions. We found that only one staff member had completed challenging behaviour training although we had highlighted this as a significant concern. None of the staff had attended mental health, equality and diversity training and six staff had completed MCA training. We saw that 12 staff had completed first aid training none of whom were the nurses and this was insufficient to provide 24 hour cover. 18 staff had completed infection control training and only one nurse attending the training. None of the staff had completed any training in respect of record keeping and care planning. From discussions with staff, the matrix and available records that we found that staff had not received mandatory training, competency assessments or training around how to work with the client group.

We found that despite raising immediate concerns about staff not having fire training in March 2015 nine staff had still not completed fire training.

This was a continued breach of Regulation 23 (Supporting workers), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

We found that the nurses and care staff on duty still could not outline what people's care needs were. We found nurses had not ensured care plans were in place for the treatment of wounds and physical health care needs. Care staff could not detail the care and support staff needed to provide. We found the information in care records remained limited. Although an overarching assessment documents was now in place this did not provide a great deal of information about the person's mental, physical and psychological needs. Also in some people's care records the previous provider documents were in place for some people's care but this was out of date.

This was a continued breach of Regulation 9 (Care and welfare) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had did not understand the requirements of the Mental Capacity Act 2005 and had not fully introduced either the principles or the appropriate documentation into the home. We found that staff believed that a number of the service users lacked capacity to make decisions and other service users had full capacity. From our review of the care records we found that staff continued to incorrectly assess service user's capacity.

We found that staff continued to send referrals for Deprivation of Liberty Safeguard (DoLS) authorisation without appropriately determining whether people had capacity. They had generically assessed people as having fluctuating capacity and we could not find the evidence to confirm this assertion. We found that staff failed to adhere to the five principles of the Mental Capacity Act 2005 and were imposing restrictions upon people although staff had not assured themselves that people did lack capacity to make decisions. We found that where people had requested to challenge the decision to subject them to a deprivation of liberty authorisation staff took no action to ensure they were supported to contact the Court of Protection to appeal this decision. Staff also took no action to ensure people had advocates where needed or when people told them they wanted to move from the home that their social worker was contacted so their care could be reviewed and a move facilitated. This contravenes the DoLS code of practice.

We found that people were deprived of their liberty without DoLS or Mental Health Act sections being in place to support this detention. This practice contravenes the Human Rights Act 1998 particularly Article 5, the right to liberty. We found that people were unlawfully detained at the Admiral Court Care Home.

We found that people who had been assessed as lacking capacity had still been asked to sign care plan documentation. Also staff had continued to fail to ascertain the legal status of family members when making decisions for service users. No information was available to determine if relatives had lasting power of care and welfare or had been appointed as a deputy by the Court of Protection. Staff we spoke with were unaware of the restrictions on a person's ability to make decisions for others and the need to have the legal authority to make care and welfare decisions.

We saw in care records do not attempt cardio pulmonary resuscitation (DNACPR) documents. We saw that they had not included any other parties in the decision making process. We noted that one person did not have contact with their next of kin but the clinical lead had not sought the input of an independent mental capacity assessor prior to requesting a DNACPR. Making this type of life changing decision in this manner contravenes the requirements of the Mental Capacity Act 2005 and associated code of practice. We found the actions of staff contravened the requirements of the Mental Capacity Act.

This was a continued breach of Regulation 18 (consent), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the home still was not Disability Discrimination Act compliant both in terms of meeting the needs of people with a physical disability and the needs of people living with a dementia. The dementia care units had not been developed to make the units dementia friendly so were not decorated in ways that enhanced people's level of independence and supported them to find their way around and to their own room. Recognised guidance had not been followed in respect of creating a dementia friendly environment such as how to use colour and material to make it easier for people to make their own way around a unit, find toilets and find meaningful occupation.

This was a continued breach of Regulation 17 (1) and (2) (Respecting and involving service users), of the Health and

Inadequate

Is the service effective?

Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at whether people who used the service were receiving adequate nutrition and hydration. We found that people were visibly thirsty and told us they had not had access to fluids and felt dehydrated. We asked staff to provide people with drinks but found this was not acted upon. We regularly checked whether people who were bedridden had drinks. We saw for one person that their jug of juice never altered and for another we saw they had juice in a jug dated 4 May 2015 and staff continued to give person fluids from this throughout the day. We never saw this being refreshed and the fluid level suggested it was the same jug of juice as to that they started with on the morning.

We found from discussions with staff that one person had compromised gag reflex. We saw that care staff were delegated to assist them to eat. In discussions with these staff we found they had not had training around how to assist people with poor gag reflex eat or how to identify if people with this condition were choking. We found that the arrangements in the home failed to ensure people safely received suitable and adequate nutrition or hydration.

We saw that the quantity of foods in the store cupboards and fridges was limited and the menu was very basic with items like hot dogs being served for the evening meal. The cook told us that they had not been able to provide what was on the menu as they did not have the ingredients. They assured us this was a temporary problem as a delivery of food from ASDA was expected the following day. We found that the cook still had not obtained a current basic food hygiene level two certificate. This qualification is required for all staff handling raw food products.

This was a continued breach of Regulation 14 (1) (Meeting nutritional needs), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said, “I liked to go on bicycle rides and walks. It was good exercise. I miss it, I just don’t do anything; I just sit here.” And, “I’m not happy here. I want to go home”.

Inadequate

Is the service caring?

Our findings

We reviewed 12 people's care records found that these remained inaccurate and incomplete. We found although some work had been undertaken to write care plans in a person-centred manner, some were extremely judgemental about the person. They made comments such as "Will cut off her nose to spite her face". They referred to people as if it was fault or due to their condition that they expressed dissatisfaction with the home rather than encouraging staff to explore why someone might be upset.

Where people were calling the police to express their concerns staff asked the family if the individual could have their phone taken off them. This was agreed even though the person had not been deemed to lack capacity and the family members did not have Lasting Power of Attorney for care and welfare. None of the concerns the person expressed were explored.

We found that staff treated people's concerns with contempt and did not acknowledge their concerns or take appropriate action such as supporting people to obtain lawyers to help them appeal their DoLS authorisations.

We found none of the nurses offices were secure and care records were stored on open-fronted shelves. We found that the provider failed to ensure the records were securely stored.

This was a continued breach of Regulations 9 (Care and welfare) and 20 (Records), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulations 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Again throughout inspection the team saw that no therapeutic activities took place. They saw that there was a total absence of meaningful activity for people across the home. Throughout the day people just sat and even a basic activity like watching the television was not available for some. People told us it was like living in a prison or worse as at least in prison there was a requirement to have an hour of fresh air a day and they had not been out of the building at all for days and for some people it had been weeks.

We saw staff responded to people's requests if they were awake, however, there was no proactive interventions from staff. The National Institute for Care Excellence (NICE) 'Dementia Supporting service users with dementia and their carers' in health and social care 2006 states:-

'For service users with all types and severities of dementia who have comorbid agitation, consideration should be given to providing access to interventions tailored to the person's preferences, skills and abilities. Because service users may respond better to one treatment than another, the response to each modality should be monitored and the care plan adapted accordingly. These guidelines also state under 'Managing risk' 'Health and social care staff who care for service users with dementia should identify, monitor and address environmental, physical health and psychosocial factors that may increase the likelihood of behaviour that challenges, especially violence and aggression, and the risk of harm to self or others. These factors include lack of activities'.

We saw staff downstairs were a little more responsive to people than at the last inspection but upstairs this was not the case and staff sat in the offices with large observation windows rather than sitting and speaking with people. We found that the staff failed to pay due regard to people's human rights and actively support them to be involved in their care and treatment.

This was a continued breach of Regulations 17 (1) and (2) (Respecting and involving service users), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

We found that care records were still inaccurate and incomplete. We could not establish why people had been admitted to the home. The care records did not detail people's needs, whether people were subject to any legal constraints such as sections of the Mental Health Act or how they were supported. We found that the assessment documents and care records gave no detail about the goals they were working towards.

This was a continued breach of Regulations 9 (Care and welfare) and 20 (Records), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulation 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the staff had not ensured people were supported to see other healthcare professionals. We found that safeguarding referrals for neglect had been upheld because staff had failed to recognise that people had developed infected wounds and this was still evident for other people, albeit the nurses had now taken action to ensure these were treated. We found that external health care professionals had raised concerns about the calibre of staff going to appointments with people and their inability to provide an appropriate history.

This was a continued breach of Regulation 24 (2) (Cooperating with other providers), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We witnessed people raising concerns about the provision in Admiral Court Care Home but saw that the acting manager and staff did not treat these as complaints; support people to raise them formally; or discuss them with the provider. We saw that external healthcare professionals had raised complaints but these had not been picked up by the acting manager so no action had been taken to ensure these were resolved.

People again told us that they had made complaints, which staff confirmed had been the case. When we reviewed the complaints file we saw that these complaints had never been recorded and therefore it could not be confirmed that this matter had been investigated.

We saw that complaints about staff sleeping on duty had been raised and the acting manager had investigated the incidents confirmed their accuracy but took no disciplinary action against the relevant staff. This contravened the provider's disciplinary procedures.

We saw that people who used the service had been assaulted by other people who used the service and had raised concerns about their safety. The acting manager had taken no action to investigate them, contact the police or safeguarding. Also it had been found that staff had wilfully neglected one person but the acting manager had not referred this to the police.

This was a breach of Regulation 19 (2) (Complaints), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us, "I don't think that there is sufficient done. When I first came here there were quizzes and things going on. With a bit of persuasion we could pick up again", "I've lived here too long" and "Nah, there's nothing to do. I don't know why I'm here. I don't get outside, it's worse than being in the nick".

People also expressed their dissatisfaction to us and said, "I haven't had a drink all morning and am a bit dehydrated", "They do nothing for me. I've got arthritis, I'm in agonising pain" and "I keep telling them I have a pain in my tummy but they do nothing about it".

Inadequate

Is the service well-led?

Our findings

We found that following the inspection in March 2015 the provider has still not taken action to ensure staff had appropriate DBS checks, received adequate training or to ensure staff were competent and equipped to meet the needs of the individuals admitted.

This was a breach of Regulation 22 (Staffing), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us that they had ensured systems were in place for overseeing the home. The acting manager told us that they had developed some systems for monitoring and assessing the effectiveness of the home. We found that the processes the home had for assessing and monitoring the quality of the service provided to people was limited and many of the audit documents were not in place or had not been completed. Staff again produced recruitment and training matrices that highlighted many gaps but told us they had yet to develop action plans to detail how to address the issues. We found that the system for monitoring the performance of the home were ineffective.

Staff again could not provide any records that would show how the provider monitored the nursing service and ensured all aspects of practice were effective and adhered to clinical guidelines. The acting manager could provide no evidence to show how the provider monitored the competency of the nursing staff or the quality of the nursing care being delivered. The acting manager told us that they did not need to check the competency of the nursing staff, as nurses were accountable for their own practice. This was incorrect as the provider must ensure themselves that all staff have the skills, experience and competency to deliver care and treatment to the people who use the service.

The provider is required to complete a review called a regulation 10 visit and report. Again no evidence was available to show that the provider completed these reviews or ensured the service operated effectively and risks were managed.

As shown throughout this report we identified that there were significant deficits in the performance of the home and skills of the staff. The provider did not have systems in place to ensure these were identified by their staff.

Staff had no understanding of the evident gaps in practice, the problems with the home or the improvements the provider intended to make to the home. Although we had issued a Notice of Decision preventing admissions on 13 March 2015 and the new certificate reflecting this as a condition of the registration the acting manager did not appear aware of this requirement. The provider had not ensured the new registration certificate was on display at the home.

This was a continued breach of Regulation 10 (Assessing and monitoring the quality of the service provision) and 20 (1) (Records), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the manager had held discussions with families and given reassurance that staff were taking action to make improvements. We noted that were families had raised concerns about issues such as lack of activities, the manager acknowledged the legitimacy of these complaints and gave told families they were working hard to ensure this was resolved. The relatives we spoke with felt the manager and staff were working hard to make the home better and ensure it met people's needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance.

The enforcement action we took:
We took enforcement action, which resulted in the cancellation of this providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not always protected against the risks associated with medicines because the provider failed to have appropriate arrangements in place to manage medicines.

The enforcement action we took:
We took enforcement action, which resulted in the cancellation of this providers registration.

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 The provider failed to take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity.

The enforcement action we took:
We took enforcement action, which resulted in the cancellation of this providers registration.

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

This section is primarily information for the provider

Enforcement actions

The provider had not taken steps to ensure people were assessed and appropriately placed at the home. The provider had not taken steps to ensure that staff were able to meet people's needs; or that any risks of serious harm were minimized. Staff failed to plan and deliver care in line with people's needs and ensure they received treatment.

The enforcement action we took:
We took enforcement action, which resulted in the cancellation of this providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services and others were not protected against the risks of inappropriate or unsafe care because an effective system for monitoring the service was not in place.

The enforcement action we took:
We took enforcement action, which resulted in the cancellation of this providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded; or protected from the risk associated with excessive heat; or those related to the use of physical intervention.

The enforcement action we took:
We took enforcement action, which resulted in the cancellation of this providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider failed to ensure that staff maintained appropriate standards of cleanliness and hygiene and protected people from the risks of infection.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We took enforcement action, which resulted in the cancellation of this providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The provider had not made appropriate arrangements for people at Admiral Court Care Home to receive sufficient support with nutrition and hydration.

The enforcement action we took:
We took enforcement action, which resulted in the cancellation of this providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People who use services were not provided with suitable equipment and sufficient quantities of equipment to meet their needs.

The enforcement action we took:
We took enforcement action, which resulted in the cancellation of this providers registration.

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 who used the service were not respected. Staff did not encourage people to lead independent lifestyles. The home had not been designed to ensure people living with a dementia and those with a physical disability were supported to remain independent.

The enforcement action we took:
We took enforcement action, which resulted in the cancellation of this providers registration.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider failed to ensure staff adhered to the requirements of the Mental Capacity Act 2005.**

The enforcement action we took:
We took enforcement action, which resulted in the cancellation of this providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider failed to ensure people were supported to raise complaints or that when they did these were thoroughly investigated.**

The enforcement action we took:
We took enforcement action, which resulted in the cancellation of this providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider failed to ensure accurate records were maintained in respect of each person using the service and the management of the home.**

The enforcement action we took:
We took enforcement action, which resulted in the cancellation of this providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider failed to ensure staff had the necessary qualifications, skills and experience which are necessary for the work to be performed and were fit to work at the home.**

The enforcement action we took:
We took enforcement action, which resulted in the cancellation of this providers registration.

This section is primarily information for the provider

Enforcement actions

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 The provider failed to ensure the staff were supported and trained to meet the needs of the people who used the service.

The enforcement action we took:
We took enforcement action, which resulted in the cancellation of this providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider failed to make suitable arrangement to protect the health, safety and welfare of the people who use the service by working in collaboration with others.

The enforcement action we took:
We took enforcement action, which resulted in the cancellation of this providers registration.