Calderdean Limited

Alders Residential Home

Inspection report

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Date of inspection visit: 03 December 2014 and 06, 09, 11, 12, 16, 20 February 2015
Date of publication: 25/06/2015

Ratings

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

Overall summary

The inspection was unannounced and took place on 3 December 2014. However in the course of finalising and analysing the information, we became aware of more serious information therefore we extended the remit of the inspection. Further visits took place on 06, 09, 11, 12, 16, and 20 February 2015.

The previous full inspection at the Alders Residential Home was carried out on 07 November 2013. The service was judged to be non-compliant in two outcomes, management of medicines and supporting workers. The home was re-visited on 25 March 2014 and the registered provider had made the necessary improvements to meet the relevant requirements.

The Alders Residential Home is registered to provide care for up to 32 older people who do not require nursing care. At the time of our visit there were 26 people who lived there. Accommodation is on two floors with a stair lift for

Summary of findings

access between the floors. There are several lounges, two dining rooms and a central courtyard for people to enjoy. The home is situated close to shops, buses and the local facilities of Morecambe.

When we visited the home on 03 December 2014 we met with the manager. The manager wasn't registered with the Care Quality Commission (CQC). 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. The manager informed us that he had submitted an application.

Prior to our inspection on 06 February 2015 we were aware the manager had received their registration with CQC on 23 December 2014. We visited the home on six occasions in February 2015. The registered manager was not present during this time. At each visit we met with a director of the company that operated the service.

During our visit in December 2014, people told us they were happy living at home. The atmosphere was friendly and routines were relaxed. We observed staff and people who lived at the home had time to spend together and enjoyed each other's company. People who lived at the home and family members we spoke with, were complimentary about the care they received from staff who they felt were knowledgeable and competent and treated people as an individual. Comments included, "Staff are very particular, they keep everything to a very high standard and they all treat me like a friend." "The staff are caring." And, "There has been a difference in the last few months for the better."

However in response to serious information we received we undertook further unannounced visits in February 2015. We were informed incidents had occurred that resulted in the suspension of staff and were being investigated by external agencies.

Through our observation and discussions with people we noted that a number of systems to monitor the quality of the service and keep people safe had failed. There were numerous breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which meant the service was not safe, effective, caring, responsive or well-led. You can see what action we told the provider to take at the back of the full version of the report.

Suitable arrangements were not in place to ensure people were safeguarded against the risk of abuse by means of responding appropriately to any allegation of abuse. There was no evidence that the registered manager had responded to concerns raised with them about care practices. You can see what action we told the provider to take at the back of the full version of the report.

Recommendations made to the registered manager and provider during our inspection in December 2014 about the maintenance at the home had not been acted upon. Work had not been undertaken to secure the building and the electrical certificate had not been renewed. Immediate requirements made by Lancashire Fire and Rescue Service had not been acted upon. Fire doors were wedged open or not effectively closing into their frames. You can see what action we told the provider to take at the back of the full version of the report.

The staffing levels at night were inadequate to keep people safe. There were two members of staff on duty. A number of people had disturbed sleeping patterns and a there had been a high number of unwitnessed falls. One member of staff told us, "If we are dealing with somebody else or getting residents up, people are left to wander." You can see what action we told the provider to take at the back of the full version of the report.

The provider did not have appropriate arrangements in place to manage medicines. There was not a clear audit trail of medicines administered. Records were signed, but the tablets had not been given to the person. You can see what action we told the provider to take at the back of the full version of the report.

Thorough recruitment practices were not followed so that the provider was assured staff were suitable for their role. You can see what action we told the provider to take at the back of the full version of the report.

Suitable cleanliness standards were not in place for keeping the service clean and hygienic to facilitate the prevention and control of infections. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

Suitable arrangements were not in place to ensure staff received appropriate training to carry out their role and responsibilities. Training requirements for staff members had been identified but not delivered. You can see what action we told the provider to take at the back of the full version of the report.

We observed that one person's liberty was deprived without the authorisation of the appropriate supervisory body.

Where people had been assessed as at risk of poor nutrition and hydration, arrangements for monitoring people's weight, diet and fluid intake was not regular or consistent. We observed staff support at mealtimes was minimal for those people who needed oversight and assistance to eat their meals. You can see what action we told the provider to take at the back of the full version of the report.

We found that people did not experience care, treatment and support that met their needs and protected their rights. This was because plans and procedures were not in place for dealing with changes in peoples` care and how best to support and protect people. We also found that the planning and delivery of care did not always take account of how best to meet people`s individual needs. You can see what action we told the provider to take at the back of the full version of the report.

Recommendations made to the registered manager and provider during our inspection in December 2014 about improving the assessing and monitoring of the quality of service had not been acted upon. The systems to monitor the quality of the service and keep people safe had failed. You can see what action we told the provider to take at the back of the full version of the report.

It is a requirement of the Care Quality Commission (Registration) Regulations 2009, that the provider must notify the Commission without delay of the death of a person who lived at the home. In addition the provider should notify the Commission of other incidents including the serious injury to a person or allegations of abuse towards a person or any incident which is reported to or investigated by, the police. This is so that we can monitor services effectively and carry out our regulatory responsibilities. We noted during our inspection in February 2015 that incidents which took place at the home in December 2014 and January 2015 should have been submitted to CQC. The registered manager or provider should have notified us. Our systems showed that we had not received any notifications.

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.

People told us they felt safe living at the home but people were not protected from risks of harm. There was not enough staff on duty at night to keep people safe and risks were not always assessed in a timely manner or appropriate action taken to keep people safe.

People were not protected from unsuitable people working in the home because the home's recruitment procedure was not followed correctly and recruitment was not safe.

Suitable arrangements were not in place to respond to allegations of abuse.

Recommendations from CQC and external services about the security of the building, electrical safety, fire safety arrangements and infection control had not been acted upon.

Suitable arrangements were not in place to ensure medicines were safely administered. This was because we found errors in the recording of medicines administered to people who lived at the home.

Is the service effective?

Inadequate 

The service was not effective.

Training had been identified but not completed. This meant staff were working without the necessary knowledge and skills to support people effectively.

Staff did not understand the requirements of the Mental Capacity Act 2005. We observed that one person's liberty was deprived without the authorisation of the appropriate supervisory body.

People who were assessed at being at risk of poor nutrition and hydration were not regularly and consistently supported and monitored to have sufficient to eat and drink.

People's health needs were not routinely or consistently managed.

Is the service caring?

Requires Improvement 

The service was not always caring.

Generally people who lived at the home and their family members told us staff were caring. We saw that staff treated people with patience and compassion and respected their rights to privacy and dignity. However we were made aware of incidents experienced by two people which did not demonstrate they had on those occasions been shown respect or dignity.

People were supported to express their views and wishes about all aspects of life in the home.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive.

There was an established programme of activities. During our observations we noted people engaged in activities. People told us they had enjoyed taking part.

Records showed people and their family members had been involved in making decisions about what was important to them. People's care needs were kept under review, however we noted care plans had not been updated or changed to manage an increase to people's safety.

Incidents had not been investigated and there had been no action taken to respond to incidents.

Is the service well-led?

Inadequate 

The service was not well-led.

Recommendations made to the registered manager and provider during our inspection in December 2014 about improving the assessing and monitoring of the quality of service had not been acted upon.

Through our observations and discussions with people, we noted that a number of systems to monitor the quality of the service and keep people safe had failed.

There was no clear leadership at the home and the provider did not understand their legal responsibilities for meeting the requirements of the law.

Alders Residential 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.

The inspection was unannounced and took place on 3 December 2014. However in the course of finalising and analysing the information, we became aware of more serious information about the service therefore we extended the remit of the inspection. Further visits took place on 06, 09, 11, 12, 16, and 20 February 2015.

The inspection team across the visits consisted of three adult social care inspectors, two inspection managers and an expert by experience who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of caring for older people.

We reviewed information we held about the home, such as statutory notifications, safeguarding information and any comments and concerns. This guided us to what areas we would focus on as part of our inspection. Before our first visit in December 2014, we asked to the provider 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. They did not return a PIR as the registered manager told us they had not received it. We took this into account when we made the judgements in this report.

We spoke with a range of people about the service. They included eight people who lived at the home, five visiting family members, three visiting health or social care professionals and fourteen staff members. We also spoke with the registered manager and the provider. In addition we spoke to the contracts and commissioning department and safeguarding team at the local authority in order to gain a balanced overview of what people experienced accessing the service.

The contracts and commissioning team told us they had been involved in monitoring the service since July 2014. They told us a number of recommendations made by their visit had been addressed by the new manager. Further on going action was in place to meet the requirements of social services contracts team. We were informed by the local safeguarding team were undertaking safeguarding investigations. These related to the safety and well-being of a number of people who lived at the home.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also spent time looking at records, which included fourteen people's support records, training and recruitment records for seven members of staff and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe at the home and with the staff that looked after them. One person told us, "The staff are always around the place it makes you feel safe."

When we visited the home on 03 December 2014 we saw there were safeguarding policies and procedures in place. Staff were knowledgeable about the actions they would take if they witnessed any abuse taking place. One member of staff told us, "I would go straight to the manager if I felt something was wrong. I have done safeguarding training and know what to do."

The inspection visits in February 2015 were carried out to assess the safety of people who lived at the home in response to information of concern that we had received. This related to the safety and well-being of a number of people who lived there. During these visits two members of staff disclosed information to us that in December 2014 they had raised allegations about care practices with the registered manager, to ensure the people they supported were protected from potential harm or abuse.

We looked at the current employment contract for staff which stated, "If you wish to make a 'protected disclosure' also known as a 'whistle blower' disclosure, you must do so to a director or the owner only." Under the Public Interest Disclosure Act 1998 (PIDA) workers who act honestly and reasonably are given automatic protection for raising a matter internally. Protection is also available to people who make disclosures to regulators such as the Care Quality Commission. It also makes it clear that any clause in a contract that seems to prevent an individual from raising a concern that would have been protected under PIDA is void. We spoke with a director of the company that operated the service about the recent change in employment contracts. She told us, "I have not read them in detail. I just bought them on line."

We reviewed people's care records, staff training and supervision records, incident and accident records and records relating to the management of the home. There was no recorded evidence to show details of the allegations staff told us they raised in December 2014, or what action had been taken. Suitable arrangements were not in place to ensure people were safeguarded against the risk of abuse by means of responding appropriately to any allegation of abuse.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Safeguarding people from abuse, (now Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.)

We asked the director if they were aware that allegations had been raised with the registered manager in December 2014. The director told us, "I don't know. The manager deals with all that kind of thing." We notified the appropriate authorities of the information staff members had disclosed to us.

It is a requirement of the Care Quality Commission (Registration) Regulations 2009, that the provider must notify CQC without delay of any abuse or allegation of abuse in relation to a service user. This is so that we can monitor services effectively and carry out our regulatory responsibilities. Our systems showed that CQC had not been notified of these allegations.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

In our discussions staff told us they were aware of the home`s whistle blowing policy. We saw the policy outlined the procedure to follow should any of the staff have concerns or suspicions where people who lived at the home were at risk. This instructed staff to raise their concerns with the management team. However there was no recognition within the policy that there may be circumstances where staff can report a concern to an outside body, such as the local authority or the Care Quality Commission (CQC). One member of staff told us they had been, "given a new contract which included a clause that they were not allowed to whistle blow outside of the company."

During our inspection in December 2014 we noted that the premises were not secure. The lock on one window was broken which meant it did not close properly and a further two windows were not restricted to open safely. This meant people could be at risk of falling due to the wide opening of the windows. We noted that people could exit the building through three external doors that were not secure or alarmed. We also noted the electrical safety certificate was

Is the service safe?

a month overdue and no arrangements had been made to address this matter. We spoke with the registered manager and provider and made recommendations about ensuring people who lived at the home were safe within the building.

During our visits in February 2015 we noted our recommendations had not been acted upon. There had been no maintenance work undertaken to secure the building and the electrical safety certificate had not been renewed. This could potentially put people's safety at risk. We spoke with the director about our concerns. She told us, "The maintenance man will do the windows when he arrives back off leave and I'll get some alarms off EBay."

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

We looked at how risks to individuals and the service were managed so that people were protected. Where people may display behaviour which challenged the service, we saw evidence in care records that risk assessments and plans of care were in place. These were detailed and meant staff had the information needed to keep people safe. We looked at one person's care records to determine what arrangements were in place to keep this person safe. A risk assessment had been completed when the person was admitted to the home in January 2015. The person had been identified as unsteady on her feet and at high risk of falls. The care plan set out the action that was required by staff, 'Care team to monitor [person] and her whereabouts at all times to maximise safety as she will try and get out of doors if she is awake and wandering around.'

Staff told us that the person lacked capacity and had left the building twice through a fire door that was not alarmed. A member of staff told us that once the door closed, the person could not get back into the home. This left them trapped outside without staff knowing where the person was. Whilst risks were identified and assessed, suitable arrangements were not in place to manage the risk or reviewed following incidents to ensure necessary action was taken to keep the person safe.

On one of the occasions when the person had left the building, staff had been unable to find the person and had reported the person missing to the Police. The person was located by the Police and safely returned to the home. It is a requirement of the Care Quality Commission (Registration) Regulations 2009, that the provider must notify CQC without delay of any incident which is reported to, or investigated by the Police. This includes people who use services going missing. Our systems showed that CQC had not been notified.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We looked at what arrangements and plans were in place to respond to emergencies. We saw a copy of the fire risk assessment action plan that had been issued by Lancashire Fire and Rescue Service following an inspection at the home on 30 January 2015. The inspection found that a fire risk assessment has been completed by the provider but was deficient in some areas. These included emergency routes and exits where a number of fire doors were either found wedged in the open position, door closing devices disconnected/ missing or not effectively closing into their frames. The action plan recorded that the provider had agreed to ensure action was taken for all areas of non-compliance by 27 April 2015, however the use of wedges/chairs to hold fire doors open should cease immediately.

During our visits in February 2015 we walked around the premises and noted this was not the case. Chairs were used to hold open fire doors in one of the corridors and both staff room offices and a number of people's bedroom doors were wedged open. We spoke with the director and asked what arrangements were in place to meet the requirements of the fire risk assessment action plan. The director told us, "It's not a problem. No need to worry about it."

We reviewed how the service was being staffed to make sure there was enough staff on duty at all times, to meet people's needs and keep them safe. People we spoke with told us they were happy with the care and support they were receiving. They told us they felt there were enough staff on duty to meet their needs and that staff had time to spend with them. One person told us, "There always seems to be enough staff." Another person told us, "Staff are very attentive and helpful."

We looked at the homes duty rota. The rotas were covered so that there were five members of staff on duty during the day 8am to 6pm, three in the evening 6pm to 10pm and

Inadequate

Is the service safe?

two at night 10pm to 8am. During our observations we saw staff were responsive to the needs of people they supported. Call bells were responded to quickly when people required assistance.

During our visits in February 2015 we looked at two people's care records who had been admitted to the home in January 2015. We noted that they both had disturbed sleeping patterns at night and were assessed as at high risk of falls. Daily records for both people reported there had been incidents where they had been out of bed during the night and suffered injury as a result of a fall.

We spoke with staff members about staffing levels at the home. One staff member told us, "There is no structure for who is doing what. No task allocation. I have suggested to the registered manager about doing things better but not heard anything back." Another member of staff told us, "Last night there were four people who were awake and up and about during the night. If we are dealing with somebody else or getting residents up, people are left to wander." They went on to explain that ten people wanted to get up and dressed in the morning before the day shift started at 8am, five of whom required assistance with personal care and mobilising from two members of staff. This meant that whilst the two members of staff were attending to one person, there was no oversight of the other people who lived at the home.

We looked at the duty rota for 08 February 2015 and noted there had been two members of staff on duty for the night shift. We also looked at the accident and incident records and noted that one person had fallen at 6am on 09 February 2015. The record noted, "Another resident came and told the staff there was a lady on the floor."

On 09 February 2015 we spoke with the director about our concerns that there were not enough staff on duty at night to keep people safe. We asked if staffing levels were assessed and monitored to make sure there were sufficient staff on duty to meet people's individual needs and to keep them safe. The director told us, "It would have been the manager's responsibility. There has only ever been two staff on at night time for the past 20 years and they can cope." However the director was unable to demonstrate what analysis and risk assessment had been used to determine sufficient staffing levels. The staffing levels at night were inadequate to keep people safe.

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

On 11 February 2015 we were alerted by the local authority that two people had been admitted to hospital the night before from the Alders Residential Home. We visited the home on 11 February 2015. We were able to talk to the staff who were on duty the night before. We were told there had been two members of staff on duty. One person who lived at the home had become ill and an ambulance had been called. Whilst the two members of staff had been attending to the person another person had attempted to walk out of their bedroom and had fallen. A serious injury was sustained and another ambulance had to be called.

A member of staff told us, "[Person] normally gets up but stands in her room. Lately she has started wandering out." There was no evidence in the care records that the person's risk assessment or plan of care had been reviewed following this change, to keep the person safe.

We reviewed the incident and accident reports since 09 February 2015. There had been two incidents in the early mornings of 10 and 11 February 2015 which had resulted in injuries for two people who lived at the home.

We spoke further with the director on 11 February 2015 about the staffing levels at night. We required that the provider engage another member of staff on duty from 10pm to 6am with immediate effect and undertake a review of staffing levels as a matter of urgency. A member of staff agreed to cover the night shift before we left that evening.

We spoke with the night shift before 8am the following morning after. There had been three members of staff on duty. They confirmed there had been no accidents during the night. One member of staff told us, "It's been better with three on. It has meant that if two of us are attending to a person at one end of the building, the other carer can check on everyone else and make sure they are alright."

We looked at how medicines were administered. We saw people's medicines needs were checked and confirmed on admission to the home. Medicines were safely kept and we saw appropriate arrangements for storing, recording and monitoring controlled drugs (medicines liable to misuse). It was however noted that a lock had become loose to one of

the storage cupboards and that this needed to be replaced. The home worked with the local pharmacy to ensure they had adequate stocks in place. There was a system in place for returning any surplus stocks of medicines.

Only trained staff administered medication. This was confirmed by talking with staff members. However assessments of competency had not yet been completed. We found that best practice guidelines were not being followed properly. At our inspection visit on 06 February 2015, we saw that medication given to people was not always observed as being taken. One member of staff stood with the medication trolley in the medication storage room, whilst another member of staff took and gave the medicines to people. The member of staff who prepares the medicine and signs the record, should also observe that the person has taken their medication.

We reviewed the Medication Administration Records (MAR) for fourteen people who lived at the home. When checking the records of one person's medication we saw a number of errors that raised concerns about how medicines were administered to people. We found that on two occasions staff had signed for administering a recently prescribed short course of antibiotic tablets, but the tablets had not been given. We found for eight people, the medicines records did not consistently provide a clear audit trail of medicines handling at the service because records were signed, but the tablets had not been given. Failing to give people their medicines properly places the health and welfare of people at unnecessary risk.

We also found that there was a lack of clear guidance about the use of medicines prescribed 'when required' to help ensure consistency in their use, when needed. One person was prescribed pain relief as and when required; up to four times a day. We noted from the daily records that the person 'complained of leg and back pain' during the night. We checked the MAR sheet which recorded that the person was offered pain relief only twice a day; at 07:30 and 19:30. They had not been offered or taken pain relief during the night. We spoke with the person and they confirmed they did 'suffer' from discomfort during the night and had not been offered pain relief.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

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

We looked at the recruitment and selection procedures the provider had in place to ensure people were supported by suitably qualified and experienced staff. At our inspection visit on 09 February 2015 we looked at records for six members of staff. All staff had completed an application form however a full employment history was not provided for all staff. There was no evidence that any gaps in employment history were explored and explained for each person. References were obtained before people started work however not always sought from the last employer.

We were told by staff on duty that Disclosure and Barring Service (DBS) checks had been undertaken before they started work. However there was only evidence on one person's file that a DBS check had been completed. Information was disclosed during the application for two members of staff. There was no evidence that they had been subject to the necessary checks so that the provider was assured that the person was suitable for their role. We spoke with the director about our observations. The director told us, "I am not aware of these. The manager would have responsibility for recruiting staff." Safe recruitment practices were not followed.

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

We spoke with a health professional, who was visiting the home on 06 February2015. We asked for their views on how well people were protected by the prevention and control of infection. The professional told us they had visited the home twice before and found the environment was not managed to minimise the risk of cross infection for people who lived at the home, staff and visitors. The professional explained they had previously sent the provider an audit report which highlighted issues found during those visits. They told us that through their observations from this visit the issues had still not been addressed and people were not protected by the prevention and control of infection.

Inadequate

Is the service safe?

We looked at what procedures and systems were in place to manage infection control in the home. We also looked around the home to see what hygiene controls were in place.

Staff were unable to locate up to date infection prevention and control policies and guidelines. Staff we spoke with demonstrated an understanding of the need to follow infection prevention and control procedures and gave examples of how this worked in practice. However when questioned, staff were unaware of the five key stages for hand hygiene. Training records we reviewed for six members of staff showed that only two of the staff had completed infection control training since starting work at the home.

We saw cleaning schedules were in place. These listed daily, weekly and detailed tasks for both the domestic and care staff. All schedules had been initialled by staff to confirm tasks had been completed. When we looked round the home we saw daily tasks for the communal and people's bedrooms had been completed. However we noted furniture was not washable. Some chairs were stained. Some bedrooms smelt strongly of urine and divan bases and mattresses were soiled with body fluids. Toilets and seat risers were dirty and stained, even in rooms that were not being used.

One room we looked at on 06 February 2015 was unoccupied but had been used the previous night. The bedroom smelt strongly of urine, the bed had been slept in but was unmade and the remnants of a meal were left on the side. We checked the cleaning schedules and found the schedule had been signed for the cleaning and tidying of that room. Suitable cleanliness standards were not in place for keeping the service clean and hygienic to facilitate the prevention and control of infections.

There was a lack of hand hygiene facilities for staff. There was no liquid soap or paper towels in bedrooms for staff to use. Hand gel dispensers at the entrance were empty. This meant basic hand hygiene facilities were not always available and maintained. People were not protected by the prevention and control of infection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Cleanliness and infection control, (Now Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014.)

Inadequate

Is the service effective?

Our findings

At our inspection in December 2014 the feedback we received from people who lived at the home and their family members was positive. People told us they felt their carers understood their needs and said they received a good level of care and support. One person commented, "The staff are brilliant. They know what they are doing." A family member we spoke with told us, "It's a good home run by staff who care."

At our inspection visit on 09 February 2015 we looked at training records for six members of staff. Records showed that none of the six members of staff had completed key training in all areas of safeguarding vulnerable adults, moving and handling techniques, first aid, medication, infection control, and fire training. Where training had been completed with a previous employer, there had been no update or refresher training since starting at the Alders. One person who had started at the Alders in October 2014 had not completed any medication training since 2007. We noted that another member of staff had no previous employment history. They started work at the Alders in October 2014 and had not completed training in any of the key areas.

The staff members we spoke with told us they received regular formal supervision sessions with their manager, in addition to an annual appraisal. These meetings gave staff the opportunity to discuss their own personal and professional development as well as any concerns they may have. We noted from the six records that we looked at, that training was identified for members of staff as part of the supervision but had not been addressed. For example it was identified for one member of staff in December 2014 that moving and handling training was required. There was no evidence to show this had taken place.

Staff members we spoke with told us that training was discussed with the registered manager. One staff member told us, "The manager is really good sitting down and discussing training but it doesn't happen, we just don't have time to do it." Suitable arrangements were not in place to ensure staff received appropriate training to carry out their role and responsibilities.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Supporting workers. (Now Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

When we visited the home on 03 December 2014 there were policies in place in relation to the MCA and DoLS. There were related procedures in place and the registered manager and senior person had received training to underpin their knowledge. This demonstrated the service had established structures to enable staff to support people who lacked capacity to make decisions. The registered manager told us, "We will eventually roll out training for all staff to attend DoLS and the Mental Capacity Act training."

During our visits in February 2015 we spoke with staff to check their understanding of the MCA. Staff were unable to demonstrate an awareness of the legislation and associated codes of practice and confirmed they had not received training in these areas. One staff member told us, "I have no idea. I wouldn't know how to test someone's capacity or when to." Suitable arrangements were not in place to enable staff to assess people's mental capacity, should there be any concerns about their ability to make decisions for themselves, or to support those who lacked capacity to manage risk.

We observed daily routines to gain an insight into how people's care and support was managed. On 06 February 2015 we noted one person spent the majority of the day walking around the home unsupervised. We looked at the person's care records. The care plan set out the action that was required by staff, 'Care team to monitor [person] and their whereabouts at all times to maximise safety as they will try and get out of doors if they are awake and wandering around.' Staff told us that the person lacked capacity and had left the building twice through a fire door that was not alarmed. There was no mental capacity

assessment or best interest decision in place to identify that it may be in the person's best interests to be cared for in a way that amounts to a deprivation of liberty in order to safeguard them.

We spoke with the director of the company operating the service and informed them that the person was being deprived of their liberty without the authorisation of the appropriate supervisory body. We asked the provider to submit an urgent and standard authorisation, in accordance with the provisions of the MCA. The director told us that she did not have an understanding of the MCA and didn't know how to complete a DoLS authorisation. The director told us she would, "Get somebody to do it." When we revisited on 09 and 11 February 2015, the provider had not completed or submitted the authorisations.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Safeguarding people from abuse. (Now Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) 2014.)

Prior to our visit on 06 February 2015 we were informed through a safeguarding alert that, "cheap" food was being purchased by the home and no fresh fruit or vegetables were available. At our visit on 06 February 2015 the cook was out shopping when we arrived unannounced. They had purchased fresh milk, fruit juice and condiments. We were shown fresh food was available. We spoke with the cook about the availability of good quality food. They told us that all the shopping was purchased from an economy range from a supermarket. They told us they had spoken with the provider and suggested the home sourced a local supplier to provide better quality food. The cook told us this had not yet been agreed by the provider.

When we visited again on 09 February 2015, the cook had purchased further fresh food and the storage areas were fuller. They told us, "I am only here to take care of my residents and feed them."

The people we spoke with told us they enjoyed the food provided by the home. They said they received varied, nutritious meals and always had plenty to eat. They told us they were informed daily about meals for the day and choices available to them. One person said, "I enjoy my food. The food is really tasty." Another person told us, "I bet we get peas and sweetcorn. We always have peas and sweetcorn. I don't like it."

There was a choice of two hot meals provided at lunchtime on the day of our inspection. Peas and sweetcorn were on the menu. We saw people were provided with the choice of where they wished to eat their meal. Some chose to eat in the dining rooms others in their own room. The people we spoke with after lunch all said they had enjoyed their meal.

At our visit on 06 February 2015, we observed lunch being served in a relaxed and unhurried manner. There were some people who needed assistance with their meals. We observed one person had a bowl of soup and a ham sandwich placed in front of them and left to eat it. The person did not touch their food. We saw that when staff prompted the person and supported them, they ate, but when the staff walked away the person didn't eat. Staff assistance was minimal and the person did not eat their full meal.

We looked at the person's care plan and noted they were at risk of poor nutrition and hydration. A nutrition risk assessment had been completed when the person was admitted to the home in March 2014. A nutrition care plan detailed that the person should have a soft diet, small meals, be prompted at meals times and diet and fluid intake to be recorded. The care plan stated, '[Person} requires a soft diet as he has no teeth to be able to chew his food and is at risk of choking.'

Care records demonstrated that the GP and dietician had been regularly involved in monitoring the person. However there was no evidence that staff at the home had suitable arrangements in place to regularly and consistently monitor the person's weight or diet and fluid intake.

In the evening we observed the person eating alone in their bedroom. Staff had left the person with scrambled egg on toast. This was not a soft diet and the person had been left alone and was at risk of choking. We called for staff assistance and asked them to sit with the person to support the person with their meal.

Not all people were supported to have sufficient to eat and drink.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Meeting nutritional needs.(Now Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) 2014.)

Inadequate

Is the service effective?

People told us they felt comfortable to discuss their health needs with staff. One person told us staff noticed if they were unwell and supported them in getting the right treatment. We noted one person was significantly underweight when they were admitted to the home. A timely referral had been made to the dietician and a plan of care put in place to address the health concern. We saw the person's condition was constantly monitored by the GP and dietician and the person had put weight on. However the records we reviewed showed the person's weight was not routinely monitored by staff at the home. In addition records were inconsistently maintained to monitor the person's dietary and fluid intake.

We noted from another person's care records that they were diagnosed as a type 2 diabetic. The care plan, dated 12 April 2014, set out the action that was required by staff. This included daily records of the person's diet and fluid intake, blood sugars to be checked four times a day and nutritional assessments to be completed monthly. There was no evidence that the person's intake had been recorded or blood sugars checked. The monthly assessments had been completed at three monthly intervals. We also noted at our visit on 20 February 2015 that the person had a diabetic health screen appointment at the hospital on 11 February 2015. We asked the person if they had attended their appointment. They told us, "I know it is due but not sure what day. I haven't been. The staff let me know when I am due." We spoke to a senior member of staff who assured us they would phone the hospital to make another appointment.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care and Welfare, (Now Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014.)

Requires Improvement

Is the service caring?

Our findings

At our visit on 03 December 2014 people who lived at the home and family members we spoke with told us they felt staff were caring and respectful. A family member told us, "The staff are so nice and helpful." Another told us, "110% I would be happy to put my mum here."

We spent time in all areas of the service, including the lounge and the dining areas. This helped us to observe the daily routines and gain an insight into how people's support was managed. Our observations confirmed staff had a good relationship with people who lived at the home. We saw that staff knew the people they cared for and showed warmth and compassion in how they spoke to people in their care. Staff were attentive and dealt with requests without delay.

We noted through our observations that staff were very patient when dealing with people who repeatedly asked them the same question in a short space of time. One person appeared distressed and agitated in the lounge area. A staff member immediately went over and sat holding the person's hand and calmed her down before supporting the person to her bedroom. We later saw the person smiling and joining in a group discussion in the lounge. We also observed a member of staff ensuring that a person's hearing aid was fitted correctly to enable her to hear properly. The person told us, "The staff are caring."

We observed staff engaging with people in a sensitive and respectful manner. Communication was a two-way process. One person told us, "The staff take time to listen. They are so good." Staff took time to talk with people on an individual basis and understand the support people required. One staff member told us, "If you don't take the time to listen and treat people with dignity and respect you should not be in the job."

Staff spoke fondly and knowledgeably about the people they cared for. All were respectful of people's needs and described a sensitive and caring approach to their role. Staff told us they enjoyed their work because everyone cared about the people who lived at the home. One staff member told us, "It is important for people to be cared for as if it was our own mum or dad." The staff showed a good understanding of the individual choices, wishes and support needs for people within their care.

The care plans we viewed were based on people's personal needs and wishes. Everyday things that were important to them were detailed, so that staff could provide care tailored to meet their needs and wishes. People we spoke with were confident that their care was provided in the way they wanted, although some people commented that they didn't get involved with their care plans as they preferred to leave this to their family. People felt their family's views were taken into account. We saw evidence to demonstrate people's care plans were reviewed with them and updated on a regular basis. This ensured staff had up to date information about people's needs.

The service had policies in place in relation to privacy and dignity. We spoke with staff to check their understanding of how they treated people with dignity and respect. Staff gave examples of how they worked with the person, to get to know how they liked to be treated. One staff member told us, "It is important that we respect people's privacy and dignity when supporting them."

People who lived at the home told us they felt their dignity and independence was respected. One person told us, "All the staff are respectful and I know they do knock before coming into my room."

The inspection visits in February 2015 were carried out to assess the safety of people who lived at the home in response to information we received. This related to the safety and well-being of a number of people who lived there.

During our inspection we observed staff interactions with the people in their care. We saw people smiling and engaged in conversation and laughing with staff members. People were relaxed and comfortable with the staff. There was a relaxed atmosphere throughout the building. We noted that staff were attentive and dealt with requests without delay.

As part of our observations we checked on people who chose to stay in their bedrooms in order to gain an insight into how their care was being delivered. We saw people were comfortable and were attended to regularly throughout the day. Call bells were responded to quickly when people required assistance. We also saw staff were very patient when accompanying people to transfer from

Requires Improvement

Is the service caring?

one room to another. This showed concern for people's well-being whilst responding to their needs and an awareness of supporting people to remain independent whilst ensuring their safety.

People told us they had a good relationship with staff, who they described as, "Caring, kind, friendly and patient." However one person told us whilst she was happy with the staff there had been a recent incident where she had been left on the commode for over an hour. It was confirmed by a member of staff that on one occasion, day staff had not been informed by the night staff that they had left one person on a commode. When they went an hour later to carry out checks, they found the person had been on the commode for over an hour.

We spoke with family members visiting their relatives. A family member we spoke with told us, "Everybody is nice and kind." However one family member told us her mother had confided in her that, "She gets upset as she often has to take communion in communal areas and another resident teases her about her religion. She also told us that her mother had said that, "At night, the night staff get a little agitated when she calls them on her buzzer." We spoke with the person and she explained that she was, "Generally happy with the girls, they are lovely, but the staff at night can be a bit abrupt." With the person's permission we raised her concerns with a senior member of staff so that their wishes were respected and their views acted upon.

Inadequate

Is the service responsive?

Our findings

Throughout the time we spent at the service on 03 December 2014, we observed staff responded appropriately to people's needs for support. We spoke with people about how they spent their time. Some comments we received from people who lived at the home included, "I choose how to spend time here, sometimes I join in with the social events other times I don't." Also, "I like watching television the staff don't mind."

People we spoke with were happy with the activities and arranged trips out when they occurred. On the day of our visit the hairdresser was visiting. In the afternoon we observed staff engaged in a group activity of games in one of the lounges. One person told us, "Since the manager has come in things have got better and staff do try and put things on in the afternoons." The service employs a part time activities co-ordinator to engage people in games and to provide support for people to follow their chosen interests. One staff member told us, "The system works well and I cover when the activities person is not here." There were pictures on the wall of social events that people had taken part in which confirmed activities were part of the routines of the service. One staff member told us, "We are trying to put on more social events since the new manager has come in more often."

The care records of people we looked at confirmed regular reviews of care were in place and any identified changes were documented and up to date. For example needs changed for a person who required pressure relief equipment for leg ulcers. The person told us, "The staff are competent in what they do." She told us the new 'pressure cushion' had helped her feel more comfortable. One staff member told us, "Care records are good and we can easily follow changed plans of care."

Throughout the day we observed staff being responsive to people's needs and spend time with people on an individual basis. For example one person wished to sit in a lounge where it was quiet away from the activity. A staff member supported the person to another lounge and sat with them for a few minutes. A staff member told us, "We work well as a team and support each other to make sure the resident is cared for whatever they choose to do."

A complaints procedure was in place and the manager had introduced a system for people and families to report any issues and concerns to them. Information was available in the service documentation and displayed around the home. Since the new manager had been in place no recorded complaints had been received. A family member told us, "Things are definitely better I know how to complain but not had to for a long while." A member of staff told us, "We try and talk to people visiting the home and residents to see if they have any issues and deal with them straight away." One person who lived at the home told us, "Any complaints or concerns I may have I always talk to the manager."

People who lived at the home and visitors we spoke with felt the new manager and staff were responsive to them if they wanted information about the care being provided, or any queries. One family member told us, "If I want to speak with the manager about something they make themselves available."

We spoke with the new manager and people visiting the home and they told us they were no restrictions on visiting times they could see their relative at times that suited them. One family member told us, "They welcome me at any time and always offer me a cup of tea when I come here. The staff are very good and don't mind what time I come." A person who lived at the home told us, "It is difficult for my family to visit me during the day. It is not a problem for the staff and manager to see my relatives after tea."

During our visits in February 2015 we noted people were supported to express their views and wishes about all aspects of life in the home. We observed staff enquiring about people's comfort and welfare throughout the visit and responding promptly if they required any assistance.

We looked at the care records of two people who had been admitted to the home since our inspection visit in December 2014. People's needs were assessed prior to their admission to the home. These identified the potential risk of accidents and harm to the person. However care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care.

One person's care records showed a risk assessment had been completed when the person was admitted to the home in January 2015. The person had been identified as unsteady on their feet and at high risk of falls. The care plan set out the action that was required by staff, 'Care team to monitor [person] and her whereabouts at all times to

Inadequate

Is the service responsive?

maximise safety as she will try and get out of doors if she is awake and wandering around.' Since admission the person had fallen once which resulted in injury and required hospital treatment. The person had also left the building twice through a fire door that was not alarmed.

The other person's care records showed a risk assessment had been completed on admission. The person had been identified as unsteady on their feet and at high risk of falls. The person had fallen three times in their first three days at the home. The care record stated the person required 30 minute observations but there was no evidence this had taken place.

The care plans had not been updated or changed to identify and manage the significant and increased risk to these people's safety. The incidents had not been investigated and there had been no action taken to keep these people safe.

We found that people did not experience care, treatment and support that met their needs and protected their rights. This was because plans and procedures were not in place for dealing with changes in peoples` care and how best to support and protect people. We also found that the planning and delivery of care did not always take account of how best to meet people`s individual needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care and Welfare, (Now Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014.)

Inadequate

Is the service well-led?

Our findings

When we visited the home on 03 December 2014, the manager wasn't registered with the Care Quality Commission (CQC). 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. The manager had been in post at the Alders Residential Home since August 2014 and submitted an application to be registered prior to our visit. This was being dealt with by CQC's registration team.

During our visit in December staff told us they were clear about the lines of responsibility and accountability. This was confirmed by talking with people. One member of staff told us, "We now have a management structure in place which is better." This meant people were clear about the management of the home and had someone they could speak with for advice or information on a management level.

Under the new manager staff told us they had developed knowledge skills and confidence to meet the needs of people who lived at the home. For example a 'keyworker' system was now in place. This system identified individual staff to care for specific people who lived at the home. Staff told us they felt more confident to support people as a result of the new management and support arrangements. A member of staff told us, "Things are a lot better. With more access to training and management support."

For example staff wanted more staff meetings regularly. A system was in place to hold meetings more frequently so that the running of the home could be discussed and any issues dealt with.

The manager had introduced audits to monitor the quality of the service. Weekly checks on medication, staffing levels and people's care plans had been undertaken. Further quality assurance checks were required for example, infection control and maintenance of the building, to ensure the quality of the service was constantly being monitored and to drive continuous improvement.

The local social services contracts and commissioning team had been involved in monitoring the service since July 2014. A number of recommendations and action had to be addressed and implemented into the running of the home. The latest report under the new management showed an improvement in the way the home cared for people although this was an on going process. One staff member said, "Things have got better and we have addressed the concerns or they are on going from the social services action plan." A member of staff told us that since the new manager had been in charge a number of staff had left and the running of the service had improved.

There was a lack of formal processes in place to get the views of people who lived at the home on a formal basis. When we asked people if they had 'resident meetings' they said no. One person told us, "They ask me if I am alright but we don't have meetings. Another person told us, "No I don't think we do. I have not been to any." We explained the comments to the manager who told us they were arranging formal meetings for staff and people who lived at the home on a regular basis. This would support people to share their concerns and ideas to improve the running of the home.

We made a recommendation to ensure people's views were sought in relation to the quality of service provided and the continued running of the service. We also made a recommendation to ensure quality assurance monitoring systems were in place and conducted on a regular basis.

Prior to our inspection on 06 February 2015 we were aware the manager had received his registration with the Care Quality Commission on 23 December 2014. We visited the home on six occasions in February 2015. The registered manager was not present during this time. At each visit we met with a director of the company that operated the service.

We found the service was not well led by the registered manager or provider. There were systems in place to monitor aspects of the service provided; however these were not effective.

We identified a number of failings during this inspection which had not been identified by the audits carried out by the registered manager. We found the staffing levels at night were not adequate to keep people safe. The provider was unable to demonstrate what analysis and risk assessment had been used to determine sufficient staffing levels. People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Whilst the registered manager told us in

Inadequate

Is the service well-led?

December 2014 that he had audited people's care records, our observations noted the care plans had not been updated or changed to identify and manage the significant and increased risk to people's safety.

At our inspection visit on 03 December 2014 we recommended further quality assurance checks were required for example, infection control and maintenance of the building, to ensure the quality of the service was constantly being monitored and to drive continuous improvement. During our visits in February 2015 we noted our recommendations had not been acted upon.

Although the registered manager and provider were made aware at our inspection in December 2014 that the electrical certificate was out of date, they had not taken steps to ensure contractors had undertaken the tests within the industry recommended timescale. In addition there had been no maintenance work undertaken to secure the building. Immediate action that had been required by the fire service to ensure fire doors were kept shut had not been addressed. There were shortcomings in the safety and suitability of the premises. Suitable arrangements were not in place to manage the risks to the health, safety and welfare of people who lived at the home.

We were made aware at our visit on 06 February 2015 that the Environmental Health Officer (EHO) had visited the home on 30 January 2015. A prohibition notice had been served to prevent the use of one of the stair lifts as people were at risk of falling as the safety seat belt was not securely attached to the body of the stair lift. We spoke with the director who told us she had since bought and installed a new stair lift. The director told us that a person had fallen from the stair lift in August 2014 and suffered injuries as a result. The incident had not been investigated and there had been no action taken to keep people safe until a prohibition notice had been served by the EHO.

Whilst the caring approach of staff we observed on the inspection was good, there were significant concerns the registered manager had not responded appropriately to allegations of abuse. Suitable arrangements were not in place to safeguard people against the risk of abuse.

There was no evidence that any comments or complaints had been taken into account and dealt with through the home's formal procedures. This meant that there wasn't an effective system in place to record people's views and to understand where improvements were needed.

We noted from the care records viewed there had been a number of incidents where people had suffered an injury as a result of a fall at the home. Accident forms we viewed did not outline full details of how the accident happened and what action had been taken. We asked the provider for records that would show an oversight or analysis of the number of accidents at the home. She told us no such records were available. This meant there wasn't an effective system in place to identify where improvements or changes might be required to a person's care or support.

The registered manager and provider did not show the necessary skills and knowledge to manage effectively. They were not fully aware of their responsibilities as the registered person. They did not have appropriate knowledge in relation to the law on Mental Capacity Act and DoLS. A person who was admitted to the home in January 2015 was being deprived of their liberty without the authorisation of the appropriate supervisory body. There was no mental capacity assessment or best interest decision in place to identify that it may be in the person's best interests to be cared for in a way that amounts to a deprivation of liberty in order to safeguard them.

It is a requirement of the Care Quality Commission (Registration) Regulations 2009, that the provider must notify the Commission without delay of the death of a person who was resident at the home. In addition the provider should notify the Commission of other incidents including the serious injury to a person or allegations of abuse towards a person or any incident which is reported to or investigated by, the police. This is so that we can monitor services effectively and carry out our regulatory responsibilities. We noted during our inspection in February 2015 that incidents which had taken place at the home in December 2014 and January 2015 should have been notified to CQC. The registered manager or provider should have submitted these. Our systems showed that we had not received any notifications.

This was a breach of Regulation 16 of the Care Quality Commission (Registrations) Regulations 2009.

On one of the occasions when a person had left the building, staff had been unable to find the person and had reported the person missing to the Police. The person was located by the Police and safely returned to the home. It is a requirement of the Care Quality Commission (Registration) Regulations 2009, that the provider must

Inadequate

Is the service well-led?

notify CQC without delay of any incident which is reported to, or investigated by the Police. This includes people who use services going missing. Our systems showed that CQC had not been notified.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who use services were not protected against the risks associated with unsafe care because care was not delivered to meet the person's individual needs and ensure their safety. Procedures were not in place for dealing with emergencies. Regulation 9 (1)(b)(i)(ii) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Effective systems were not in place to monitor the quality of the service delivery. Regulation 10 (1)(a)(b) (2)(b)(iv)(c)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People were not protected against the risk of abuse by not responding to allegations of abuse and depriving a person of their liberty. Regulation 11 (1)(a)(b) (2)(a) (3)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Suitable cleanliness standards were not in place for keeping the service clean and hygienic to facilitate the prevention and control of infections.

This section is primarily information for the provider

Enforcement actions

Regulation 12 (1)(a)(b)(c) (2)(a)(c)(i)(ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs Suitable arrangements were not in place for ensuring people were protected against the risks of inadequate nutrition and hydration. Regulation 14 (1)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Suitable arrangements were not in place to ensure the premises were adequately maintained or secure. Regulation 15 (1)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Effective recruitment procedures were not in place to ensure the person was suitable for their role. Regulation 21 (a)(i)

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Staffing levels at night were inadequate to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Suitable arrangements were not in place to ensure staff received appropriate training to carry out their role and responsibilities. Regulation 23 (1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services During the period of inspection, deaths of people who lived at the home had not been notified to CQC. Regulation 16 (1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents During the period of inspection, incidents involving people who lived at the home had not been notified to CQC. Regulation 18 (1)(2)(a)(e)(f)