Eastern Healthcare Ltd

St Edmunds Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 23 and 30 June and 6 July 2016 and was unannounced. St Edmunds Residential Home provides accommodation and care for up to 39 older people. At the time of our inspection there were 37 people living in the home.

The service had a registered manager 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.

The provider had not ensured that the water system in the home was safe. Following concerns raised by health professionals a full risk assessment of the system was carried out by an external contractor. This found that the water system was at high risk of the legionella bacteria. The legionella bacteria can cause Legionnaires disease. This is a pneumonia type infection that affects the lungs and respiratory system which can prove fatal in a small percentage of cases.

Hot water temperatures were very high in many people's ensuite bathrooms. This presented a risk of scalding. These high temperatures had been known about for several months, but no corrective action had been taken.

In order ensure that no further people would be exposed to the risk of harm whilst the water system in the home was being made safe we issued an urgent Notice of Decision to prevent the provider admitting further service users to the home. This means that that the provider's registration to operate the home is conditional upon no new service users being admitted.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

This inspection found that the provider was in breach of four regulations. These related to safe care and treatment, staffing, meeting nutritional and hydration needs and governance.

Several people enjoyed alcoholic drinks. However, no risk assessments had been carried out to determine whether there were any risks to people from this, and if so, how these could be mitigated. For example, alcohol can adversely interact with medicines.

People were not always weighed on a regular basis. This meant that where people were at risk of not eating enough, it could have been identified earlier. Steps then could have been taken to provide additional support sooner.

Medicines were stored safely, but at a higher temperature than was desirable. Excessive temperatures can affect the stability or effectiveness of some medicines and prescribed creams. This could result in people's not receiving effective relief for their symptoms.

Improvements needed to be made to ensure that enough staff were deployed to meet the needs of people in the afternoons and overnight. We observed a lunchtime where people would have benefited from more staff being present.

People did not always have access to extra fluids in hot weather, which put them at risk of dehydration. There was no separate provision for people requiring a diabetic diet in the home. A blanket approach meant that those who did not require a reduced sugar diet had desserts made with half amounts of sugar. This would not have been beneficial to those requiring gaining weight.

People living in the home had not been diagnosed with dementia. However, some people had poor short term memory, some lived with anxieties and some people periodically displayed behaviour that challenged others. We saw from people's daily records that some situations could be handled in a more appropriate manner. Consequently we have made a recommendation regarding staff training for dealing with behaviour that challenges.

Staff were caring and we received positive comments from people. However, we observed some practices where it was evident that staff did not consistently respect people's privacy, dignity or independence.

The standard of people's care plans was variable. These were not always person-centred and care plans were not always in place to provide staff with the guidance they needed to be able to support people effectively with various physical or emotional health conditions.

People felt confident to raise any concerns if they had them and found that staff and the management team were approachable and friendly.

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.

Suitable precautions had not been taken to reduce the risks to people from the legionella virus or poor water temperature control.

Arrangements were not in place to ensure that gaps in the staffing rotas for afternoon and night shifts were filled to cover staff sickness and leave.

Medicines were not stored at a safe temperature.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Suitable arrangements were not in place to support people requiring a diabetic diet or to ensure people had enough to drink.

Training was required to equip staff with the knowledge to respond appropriately to behaviour that challenged.

Consent was sought before people were supported by staff.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some practices in the home did not promote people's privacy, dignity or independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not always in place to guide staff in how to meet people's health or emotional needs.

People knew how to make a complaint and were confident that if they were to make a complaint it would be appropriately

investigated.

Is the service well-led?

Inadequate

The service was not well led.

The provider had failed to take action when high temperatures were recorded in the taps.

The provider had failed to ensure that a legionella risk assessment had been carried out in a timely manner when they took over the operation of the service.

St Edmunds 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 brought forward as a result of concerns raised by health professionals regarding the safety of the home's water system. We checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

This inspection took place on 23 and 30 June with two inspectors and by one inspector on 6 July 2016. The inspection was unannounced.

Prior to this inspection we reviewed information we held about the service. We reviewed statutory notifications we had received from the service. Providers are required to notify us about events and incidents that occur in the home including deaths, serious injuries sustained and safeguarding matters. During this inspection we spoke with health professionals including environmental health officers, officers from Public Health England and the local authority.

During the inspection we spoke with seven people living in the home and relatives of two people. We made general observations of the care and support people received at the service throughout all three days. We also spoke with the registered manager, deputy manager, three care staff and the cook.

We reviewed five people's care records and two people's medicines administration record (MAR) charts. We viewed three records relating to staff recruitment as well as training, induction and supervision records. We also reviewed a range of management documentation monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

We commenced this inspection as a result of concerns raised by health professionals regarding the safety of the home's water system. The provider told us that a legionella risk assessment had been due to be carried out in six weeks' time. However, due to the concerns raised this had been brought forward.

An external company had been engaged to carry out the risk assessment. Their report found that the water system was at high risk for the legionella bacteria. Consequently, both hot and cold water systems were flushed through with disinfectants. The report advised that an effective control system needed to be implemented because the measures that had been in place were not robust. Substantial remedial works were also required. These included replacing one water storage tank, a water heater, whirlpool baths, several taps, some toilet cisterns and various changes to the home's plumbing pipework. All toilet cisterns and taps not due for replacement required deep cleaning and descaling. By the end of this inspection progress had been made. Staff had been trained on the effective minimisation of risks from the legionella bacteria and relevant cleaning schedules had been implemented. Other more complex work required was ongoing.

People's rooms had ensuite facilities. Records showed that hot water taps were as hot as 65 degrees centigrade. We sampled ensuite sink tap temperatures across all three floors in the home. On the upper two floors, in every room we sampled, the water was too hot for us to keep our hands under the water stream. The hot water from most taps was at a temperature that could put people at risk of scalds.

The legionella risk assessment identified that a few taps had thermostatic mixing valves fitted. However these were the wrong type which did not have a failsafe device to shut off the hot water supply if temperatures began to rise. All taps in the home required appropriate thermostatic mixing valves to be fitted to protect people from water temperatures that were too hot.

One shower in the home had a recorded temperature of 33 degrees centigrade in recent months. This was too cold for people to shower in in comfort. Again, this had been known about but no corrective action had been taken.

The provider had not ensured that people were protected from the serious risks associated with the legionella bacteria and poor water temperature control. Consequently, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other environmental risks were managed appropriately. We saw that fire safety, gas, electrical, emergency systems and lifting equipment were maintained and serviced as required.

Medicines were stored securely in the home. However, this room was very hot. Temperatures were being recorded in the mornings before the hottest part of the day. We saw that on most days the temperature recorded was at or exceeded the maximum recommended for the safe storage of medicines. Excessive temperatures can affect the stability or effectiveness of some medicines and prescribed creams. This could

result in people's not receiving effective relief for their symptoms.

We reviewed the Medicine Administration Record (MAR) charts for two people. One person had not received a tablet they had been prescribed for the previous lunchtime. The tablet was still in the dispensing pack. No explanation had been recorded for this.

Another person's tablet was missing from their dispensing pack, but the MAR chart had not been signed to indicate that the person had received it. This person was also prescribed a cream that needed to be administered twice a day. There were several gaps on the MAR chart for the administration of this cream. The staff member told us that the person often declined to have this cream administered. We could not be sure in these circumstances whether people had received their medicines as prescribed.

These concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "They're as regular as clockwork with my medicines." One person's relative told us, "[Family member] takes medication and always receives it on time."

We shadowed a senior care staff member whilst they completed their morning medicine administration round. They understood which medicines were time critical. For example, they told us how they ensured that people who required repeat doses of the same medicines at lunchtime received their morning medicines at the beginning of the morning administration round. This helped to ensure that sufficient time had elapsed before their second dose.

We received mixed views about the staffing provision in the home. Some people and staff raised concerns about staffing arrangements. One person told us, "Sometimes they're short." Another person said, "There seem to be enough staff about." One staff member told us, "There's enough staff put on shift, but we don't get sickness and holidays covered well enough. This means that sometimes people get up or go to bed later than they want to." Another staff member said, "There's lots of sickness and some shifts don't have enough staff on duty. We don't have time to spend talking with people generally. We used to help out with activities for an hour or so sometimes, but we don't have time to do this anymore."

The manager told us that they required six care staff on in the mornings, five care staff on the afternoon shift and three care staff overnight, but sometimes they managed on four staff on an afternoon shift and two staff overnight. They told us that they did not use a dependency tool to determine how many staff were required to meet people's needs, but used the same staffing levels that had customarily been in place over time.

We reviewed staffing rotas for 28 days prior to this inspection. These showed that morning shifts were fully staffed but 46% of afternoon shifts had less than five staff members on duty and 25% of night shifts had two staff on duty. The manager told us that they had recently registered with a staffing agency as they had a small reserve of bank staff that sometimes did not arrive for work when expected.

Staff deployment at lunch time needed adjustment. There were often few staff members in the dining area, sometimes none at all. Some staff members were observed to be taking their breaks at this busy time. Some people needed encouragement and support to ensure that they ate enough but they did not always receive this.

There were not enough staff deployed on a substantial number of afternoon and night shifts. This meant

that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed several people enjoying alcoholic drinks. One person told us, "I love a tipple." However, risk assessments had not been carried out to determine whether this posed any risks to people's health and welfare. Alcohol could interact with prescribed and over the counter medicines. It could enhance the effect of some medicines and reduce the effect of others, either of which could be detrimental to people's health. Risk assessments were needed to determine whether there were any risks to people from drinking alcohol, and if so, how these could be mitigated.

We reviewed the weight records of four people living in the home and found that three people had been weighed three times in 2016 and one person had been weighed four times. Two of these people had steadily reducing weights. We saw that professional advice had been sought in respect of both people's weight loss. However, had they been weighed on a more regular basis patterns of weight loss would have been identified sooner which would have enabled them to benefit from professional support earlier.

The manager told us that people with diarrhoea were isolated in their rooms for three days and this had been the practice in the home for several years. This practice was referred to as 'Infection Control'. The manager explained that most people were happy to stay in their rooms as they might not be feeling well anyway. One person we spoke with confirmed that they were happy to be in their room under these circumstances. Whilst isolation was good practice where the cause of diarrhoea might be infectious and there was no clear alternative cause, no individual assessments had been made to determine whether this was the case every time someone had diarrhoea. For example, the manager told us that they thought one person's diarrhoea was caused by them eating chocolate but they were still isolated in their room on occasions.

These concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person who had been living in the home for six months had no assessment carried out to determine their risk of developing pressure areas. In all other care plans we reviewed we found that risk assessments were in place for pressure areas and information showed how these risks were managed and what support people received. Risk assessments were also in place for falls and we saw how these risks were being managed and observed how people were supported with their mobility.

We reviewed the recruitment records for three staff members and found that improvements were required in the recruitment process. One person had commenced work before any references had been received. Their application form had not been signed or dated. However, a check for criminal convictions had been carried out before they commenced duties. Their references had been completed by individuals who stated they were employed by the business the applicant had previously worked for. However, in both instances the references had been provided in the referee's personal capacity from their residential address. They were not from the person's employer. This meant that there was a risk that reliable references had not been obtained.

The majority of staff had received training in safeguarding. Training records showed that five staff had not received safeguarding training. Experienced staff were able to tell us about safeguarding. They were clear of the actions they would need to take if they suspected abuse, or if an allegation was made so that effective procedures were followed to uphold people's safety. We spoke with one staff member who had been in post for one month, but had not undertaken any safeguarding training yet. They were not able to tell us about

safeguarding or whistleblowing procedures in the home or what actions may need to be taken if they had any concerns.

Requires Improvement

Is the service effective?

Our findings

One day of our inspection was particularly hot. We noted that people in the communal areas in the afternoon did not have cold drinks available to them. The manager told us that they had noticed the same thing that morning. However, they had not taken steps to ensure this was rectified. The lack of drink availability put people at risk of dehydration.

The cook did not have a list of people who required a diabetic diet in the kitchen. They told us that they made all cakes and custard with half the amount of sugar that a recipe required. This meant that the majority of people living the home who had no need for a controlled sugar diet received food that may not have been to their liking. The cook was unable to tell us what other measures were in place to support people needing a diabetic diet. Suitable arrangements were not in place to support people requiring a diabetic diet.

A community nurse had asked staff to record one person's nutritional intake because they had been concerned about the person's blood glucose levels. We reviewed the last three days records. On two days no nutritional intake was recorded at all until 3pm. On the third day no nutritional intake was recorded after 11:45 am. Where fluids had been recorded, this was not done in millilitres. Staff had recorded liquids as, for example, 'one pot of tea' or 'one cup'. Nutritional recording was inadequately carried out. This meant that the nurse would have been unable to determine whether the person's was receiving a suitable diabetic diet.

We observed a lunch time in the dining room. One person had been assisted to the dining room 20 minutes before meals were served. They said, "They always put me here first. I don't know why. I hate it." People were not offered a choice of drinks to accompany their meal. Water was poured into glasses on the tables.

The service of meals was not organised to ensure that people sharing a table received their meals at the same time. One person had spent 10 minutes watching other people seated eating their meals whilst theirs had not been served. There were not always staff available to encourage and support people to eat their meals.

These concerns constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person who ate a pureed diet told us that the food they received was good. They added, "We can have our meals when it suits us. Some people have just finished their breakfast." Another person said, "The food is okay, but I'd love a bit of cake sometimes with my late evening drink." We read that one person had expressed a wish for, "..more custard desserts as they are tasty and easy to eat."

The cook told us that care staff asked people the morning before so that they could choose their lunch and tea time choice for the next day. We heard people asking what was for lunch as they couldn't recall what they had chosen. There were no menus on tables or any indication in the dining room of what was available.

One person was provided with specially adapted cutlery which was easier for them to use.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The provider told us that their policy was not to admit people living with dementia. The manager advised us that everyone living in the home was able to consent to their care and support and that no DoLS applications had needed to be made to the local authority. Consequently, no mental capacity assessments had been carried out.

Staff sought people's consent prior to assisting them on a day to day basis. We observed that this was done in an informal manner which gave people the opportunity to decline support.
However, the daily care records for one person who was under 'Infection Control' stated that the person had asked a carer 'whether they were allowed downstairs' that day.

Staff undertook a variety of training and we noted the vast majority was up to date. This included areas such as safeguarding, mental capacity, dementia and prevention of pressure areas. Care staff were responsible for writing people's care plans. One staff member told us, and we saw records to show, that staff felt that they had not received sufficient training or support to do so effectively. The area manager was planning to provide staff training for this in the coming weeks

One staff member said, "I last had a supervision about six months ago. Since then there's been no opportunity to review my practice or discuss development needs." Staff were due supervisions on a quarterly basis. These were behind as 25% of staff had not received a supervision in 2016. The manager told us that they were aware they needed to catch up with them.

Whilst no-one living at the home had been diagnosed with dementia, some people had memory loss and anxieties that could result in frustration. One person had confusion resulting from their health conditions which meant that their behaviour had become challenging for staff. We saw examples in the person's daily records which showed how staff had responded to them declining to get out of bed or get dressed. These situations could have been handled more appropriately.

We recommend that the service seeks training and support for staff in managing behaviour that challenges.

We found that people had access to range of healthcare professionals to help maintain their wellbeing. These included community nurses, mental health practitioners and chiropodists. One person told us, "They'll always fetch the GP in if we need them." Another person said, "I've got a hospital appointment this afternoon. They've arranged the transport for me here. All done."

Requires Improvement

Is the service caring?

Our findings

Some of the practices we observed in the home did not uphold people's privacy, dignity or their independence. We observed staff talking on the phone in the reception area regarding people's health appointments or conditions. When people used the dining area their walking aids were stored outside the dining room. This meant that people had to wait for staff support and were unable to leave the area independently. Sometimes there were no staff in the dining area for several minutes at a time.

Some of the staff dialogue in communal areas, was demeaning. For example, instead of staff speaking with colleagues at close quarters about people requiring assistance, some staff tended to call across the home to colleagues referring to people by room numbers. A relative had queried whether their family member, who required staff support with meals, had had their lunch yet. The staff member replied, "We normally feed her later."

During the lunch time period one person asked if they could change their mind and have scampi instead. The staff member said, "There's no scampi today. Try to eat it." They did not offer an alternative that the person may have found more appetising. One person had paused whilst eating their lunch. The staff member asked whether they had had enough and when the person didn't respond removed their plate. One person's chair was too far away from the table and was having difficulty reaching the plate. Staff had not noticed.

A relative told us, "Staff are very caring. [Family member] can't see very well, so they make sure to tell them who it is when they are speaking." We observed a staff member advising one person who was visually impaired where on the table their drink was. The person raised their hand in acknowledgement. The staff member had assisted the person whilst enabling them to maintain their independence. Another relative told us how a staff member had presented a rose to their family member on an important anniversary for them as they knew it was what their family member's husband had done in the past. "[Family member] was so touched, it was lovely." We saw written compliments from relatives too. One stated, "Thank you for giving [family member] such a perfect day to celebrate her birthday. She had a wonderful, memorable day." A second letter stated, "Thank you for looking after [family member]. We know she is really happy and settled. It's been super to see her make friends as she finds this difficult to do."

One person said, "Staff are very approachable and respectful." One person told us, "I've no grumbles with the staff here at all." We observed people knocking on people's doors before entering their room. One person said, "Staff will ask to close my curtains if I've forgotten to do it. I don't want people looking in when I have the light on at night." Another person told us, "Staff are very caring."

One person told us, "They speak with me about my care, but not regular, when there's something to discuss really." A relative told us that they had been asked about their family member's care needs when the person moved in, but that they hadn't seen any care plans since or been involved in any reviews. However, a review of their family member's care arrangements had been planned with a staff member.

There had been two resident and relative meetings in 2016, the first one being in January. However, the primary reason for the second meeting on 4 July had been to speak with people about the issues regarding the water system. Relatives had also been invited to both meetings. Minutes from both meetings showed that people and relatives were encouraged to ask questions, comment and make suggestions. We saw that people commented on aspects of support such as food and leisure activities. The service managers updated people on environmental improvements, maintenance and staffing issues.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed and recorded. However the standard of people's care records was variable. Some records were more person-centred and detailed than others. We did not find care plans for specific needs, for example, for diabetes or for people experiencing confusion or anxiety. We also found that some care plans had not been reviewed for several months. One staff member told us, "I have three care plans I am responsible for, but I have no time to do them to the standard I would want to." A consistent approach was required to ensure that staff had sufficient guidance to be able to understand people's needs and plan to meet them effectively.

Some people living in the home pursued their own interests. Several people had a newspaper delivered. Some went out independently. One of these people told us, "I just tell them when I'm off and when I should be back by."

Three people told us they wanted to do something mentally stimulating. One of them said, "I see there's singing and games going on sometimes but I want to keep my brain going. I've heard they're going to start bingo, I'd like that." Another person said, "We used to play bingo here, so we have the equipment. We used to pay 20p towards prizes, but we don't need to have prizes." A relative told us, "I used to visit [family member] and come in to find her playing cards with staff. That doesn't happen anymore. Staff just don't have the time."

There was activities provision, but people told us that this didn't always happen. One person said, "The person who does the activities has been on leave and no-one has covered them. And when they're here and we're short staffed they have to help out." Staff sometimes assisted a group of people to visit the neighbouring hotel for drinks. Some people were assisted in wheelchairs. Several people told us how much they enjoyed the flower arranging.

People told us that they were happy with the quality of the care provided. One person living at the home told us, "It's fine here. The home is clean and comfortable." Another person told us, "It was my choice to come and live here. I wanted to be by the sea." A third person stated, "I'm happy with things as they are." People felt that their wishes and preferences were respected. One person said, "Sometimes I like to get up early, but I didn't feel like it today. And the staff are fine with it." A relative told us, "Sometimes I go by and see that some people are up at 11 pm. It's nice to know that they aren't pushed off to bed early if they'd rather be up."

One person told us that their religion was important to them. They showed us a 'friendship book' that they were carrying around with them and explained what this meant to them. The said, "I think we have a service here once a month. I like to go to church but am reliant upon a friend for this. But I'm okay." They told us that they liked reading and showed us the extensive collection of books available for people to read in the home. They told us cheerfully, "I spend my time messing about really, so I haven't got time to read all this lot. But there are some good books here. "

People felt that the service managers would respond positively and appropriately if they had any concerns. One person said, "They don't hide up or get mean if you want to speak to them about something." Another person said, "I'd be more than happy to raise any concerns. I just don't have any." A relative told us, "I would go to the manager with any issues. They are very approachable and visible in the home."

Inadequate

Is the service well-led?

Our findings

The provider had been registered as responsible for the location since 30 November 2015. They told us that upon taking over the home, maintenance works had been prioritised on the electrical systems. We were advised that a legionella risk assessment had been due to be carried out six weeks after the concerns arose. As a result of the concerns this had been brought forward.

The provider had a policy relating to legionella which had been reviewed in October 2015. This detailed precautions such as making sure water was not allowed to stand for long periods, water tanks were covered and thermostatically controlled valves were fitted to prevent the risk of scalding of burns. The risk assessment carried out on 20 June 2016 by the external contractor found concerns in all these areas.

Monthly water temperature checks were recorded. These showed that the high temperatures had been putting people at risk of scalding for several months. No action had been taken to remedy this. We spoke with the provider's maintenance consultant. They told us that did not know that the wrong valves had been fitted on some taps. The provider had failed to ensure that the maintenance consultant had the necessary knowledge and skills to ensure the water systems were safe. They had failed to assure themselves that the water system in the home was safe at the point they became responsible for the home. This meant that they had not assessed or mitigated the risks to people living in the home from the legionella bacteria.

Despite recording consistently high temperatures in the room where people's medicines were stored, no corrective action had been taken to rectify this.

These concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we were notified by health professionals regarding the safety of the home's water system we spoke with the provider. They gave us a verbal assurance that they would not admit any new service users whilst the water system was being investigated. This was confirmed in writing on 17 June 2016. We commenced our inspection on 23 June 2016. We asked the manager and provider whether there had been any new admissions to the home since the written undertaking was provided. We were told that there had been no admissions.

However, we observed an admission record on a desk indicating that one person had been admitted to the service on 20 June 2016. The manager then confirmed that they had admitted a service user to the home. This was not a responsible course of action given the concerns regarding the risks from the water system in the home and was not commensurate with open and transparent service management.

Auditing systems were in place, including medicines audits, infection control audits and care plan audits. We also saw that the provider regularly carried out their own audits. These had identified the same issues with care plans that we had found. We saw that staff had been open with their concerns regarding staffing levels which they had conveyed to the provider during these audits.

People living in the home, their relatives and staff were positive about the leadership and management of the service. One person told us, "It's all organised well here." One staff member said, "The managers are approachable and I'm happy to speak with [the provider] too."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's welfare from alcohol consumption, nutrition and the management of diarrhoea were not suitably assessed or mitigated. Medicines were not stored or managed safely. Regulation 12 (1)(2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to identify the risk of legionella or to mitigate the risks to people from high water temperatures. Regulation 17 (1)(2)(a)(b)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient staff members were not always deployed to meet people's needs. Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that the premises were safe because the water systems were at high risk for the legionella bacteria and the water temperatures were too hot. Regulation 12 (1)(2)(d)(h)

The enforcement action we took:

We imposed an urgent condition to prevent admissions to the service.