E Nanayakkara

Allendale House

Inspection report

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Ratings

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

Overall summary

The inspection took place on 23 February 2015 and was unannounced. The service was last inspected on 20 June 2013 and we found that all of the areas assessed were met.

Allendale House is located close to the centre of the market town of Hedon and within walking distance of shops, leisure and health services. It is a relatively short walk to access local public transport. The home is owned by an individual and registered to accommodate up to 20 older people. It provides support for people with needs associated with old age and/or dementia.

There was a registered manager in post at the time of the visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service.

Summary of findings

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.

We found that there were not enough staff to support people with the meeting of their needs, records required improvement, control of infection was not adequate, people's dietary needs were not effectively met and the quality assurance systems were not effective. You can see what action we told the provider to take at the back of the full version of the report.

We made recommendations about best practice for people with dementia needs and regarding the principles of the Mental Capacity Act 2005 (MCA).

Staff were aware of and had received training in the safeguarding of vulnerable people from harm. Risk assessments were in place which supported people to live their lives whilst being protected from harm. However, we saw these required improvements.

Staff were recruited through procedures which helped to make sure they were suitable to work with vulnerable people.

Systems were in place to support people with receiving their medication although minor improvements were required with this.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the MCA legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. Although staff had received training in this some improvements were required in practice.

Staff had received training to help them with their role and systems were in place to makes sure peoples physical health needs were met.

There had been no changes to the environment to support people with dementia needs.

People were supported by a care planning system which helped identify their needs and provide information to staff so the correct support could be provided. Improvement was needed to this to ensure peoples choices and wishes were fully recorded.

People were treated with dignity and respect and systems were in place for people to be consulted or to raise concerns. However, the quality assurance systems required improvement to ensure people were consulted effectively.

Staff told us they felt able to raise concerns to the manager. We were told that no complaints had been raised with the home by staff or people who lived there.

We asked the manager to review a concern with medication and to forward this to CQC. This was not received.

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?
The service was not safe.

People were not supported by adequate numbers of staff.

Staff were recruited correctly and had been trained in safeguarding people from harm.

Risk assessments were in place but required improvement and the systems to prevent and control infection were not adequate.

Requires improvement

Is the service effective?
The service was not effective.

People's dietary needs were not adequately met.

Staff had received training but were not following latest best practice guidance for people with dementia care needs.

Peoples health needs were met but support in relation to the MCA required improvement.

Requires improvement

Is the service caring?
The service was not always caring.

Staff respected people's privacy and dignity. Care planning did not always include enough information about people their choices and wishes.

Requires improvement

Is the service responsive?
The service was not always responsive.

People were not supported with activities and staff had little time to spend with people.

There was a complaints system in place to support people should they have any concerns.

Requires improvement

Is the service well-led?
The service was not well led.

There was a quality assurance system in place which included consultation of people who lived in the home. However, this did not fully reflect people's views.

Audits had not identified the required improvements that we found during the inspection.

Records keeping in the home required improvement.

Requires improvement

Allendale House

Detailed findings

Background to this inspection

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

This inspection took place on 23 February 2015 and was unannounced.

The inspection team consisted of three inspectors. One inspector assisted for the first two hours of the visit and then the third inspector took over their role. Prior to the visit we contacted the local authority commissioning and safeguarding teams. We reviewed information we held about the service and this included notifications we had received from the registered provider. We did not request a provider information return (PIR) on this occasion. 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.

During the visit we spent time talking with eight people who used the service, two visitors, four staff and the registered manager of the home. We observed daily life, reviewed five care plans, four staff files and records in relation to the management of the home. We also asked the manager to send us additional information following the inspection but this was not received.

We received feedback from four professionals about the service.

Requires improvement

Is the service safe?

Our findings

When we spoke with people living in the home no-one raised any concerns about their safety. When we asked one person if they felt safe they said “Oh yes”.

One professional told us they felt the home was safe and risks were managed.

However, people did raise concerns about staffing levels they said, “The issue is staffing, if they get an emergency there’s no one on the floor”. However, they also said the manager helped and said, “She’s quite good, she’ll help feed people.”

Another visitor told us they felt there was not enough staff. They said, “I always think there aren’t enough carers. Sometimes if I’m in the big room, I think what would happen if something happened. I don’t think they’ve enough time to do all the things they’d like to do. There aren’t enough carers, two girls have just gone to Australia. They’ve had a change-over with cooks, they’re short of a cook at the moment".

One person who lived in the home talked to us about life in the home, including whether they liked it and about staffing levels. They said “You have to wait for their time, sometimes half an hour and sometimes more. They’re short staffed, that’s the trouble, they’ve got to hurry, and I feel sorry for them" then also added “Sometimes I’m in pain waiting.” We asked another person if their needs were met and they said “They don’t have the time, we’ve had staff problems. I don’t think they’ve enough time to do all the things they’d like to do.”

We looked at the quality assurance surveys completed in November 2014 and saw that people had commented there were not enough staff and at times they had to wait for their buzzer to be answered. The quality assurance system did not include any details of actions taken by the manager in response to this and this was discussed with the manager at the inspection.

The manager told us there were three care staff, a domestic and a cook on duty on the day of the visit. They confirmed they did not use a dependency tool to decide how many staff were required in the home and that there were between 2 and 3 staff on duty each day. The manager confirmed there were 18 people living in the home at the time of the visit.

Throughout the inspection the registered manager and staff were supporting one person with end of life care. The manager told us this had impacted on the time staff had available for other people in the home.

We observed staff were busy throughout the day and had little time to spend with people. The majority of people sat in the main lounge which was also the main walkway to the office area of the home. People were provided with no activity apart from the television being on. However, some people did have a visit from the hairdresser that day. On one occasion staff did not offer support at lunchtime when someone asked for help and at other times people were sat without interactions from others.

We observed an incident were one person was assisted by staff to access the garden to complete a time limited task. When this person wished to return to the lounge there were no staff available and there was a clear risk of harm. We had to assist this person to gain access to the home to prevent a perceived risk.

This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. You can see what action we have asked the provider to take at the back of this report.

When we spoke with staff they were aware of safeguarding vulnerable adult’s information but required slight prompting to be able to discuss this in detail. One member of staff told us they had received training as part of their induction programme and once they realised what we were referring to, they confirmed the training and could describe different forms of abuse and what they would look for. We were told, “I’ve got to know most of the people who live here, if they flinched, I’d report it.”

Staff were able to explain what they would do if they had any concerns and said that they would feel confident in reporting any issues to the manager or senior member of staff on duty. One member of staff said that if they thought an issue had not been taken seriously they would have no hesitation in “Calling the police”. However, staff were unaware of the safeguarding adult’s team or being able to contact CQC. This meant people were supported by staff who had some knowledge on how to support people with any concerns.

Requires improvement

Is the service safe?

Good recruitment practices had been followed by the home before staff commenced work. When we looked at staff files we saw evidence that the home had obtained two written references and Disclosure and Barring Service (DBS) checks. These helped identify if people were suitable to work with vulnerable adults and whether they held a criminal conviction which would prevent them from working with vulnerable people.

One professional told us they felt risks were managed in the home. They told us how staff used 'behavioural techniques' rather than medication to help support people with their behaviours.

People's files included risk assessments. These detailed different areas of need, for example, risks with moving and handling, the risk of developing a pressure sore and the risk of a person becoming distressed. The assessments described the likelihood of the risk occurring and included information on how to support the person with the risk. For example, one person was at increased risk when they took a bath; the information in the risk assessment identified they required one to one support with this task to help prevent an injury occurring.

Records evidenced the majority of risk assessments were regularly reviewed and up to date to help make sure information was available to staff which was accurate. However, we saw that in one instance a person had been identified as having a risk with their mental health or behaviour for example, confusion. The risk assessment had been reviewed in December 2014 and the risk score had increased from 16 to 30. However, although the supporting information had recorded in November that the risk was increasing, there was no information to identify what actions had been taken in response to this and how the persons' support had changed to manage the increasing level of risk.

There was a medication policy held in the home which provided guidance to staff on the safe handling of medication. This included checking medication when received to make sure the correct amounts had been delivered and how to dispose of medication no longer required.

We observed medication was stored securely and temperatures were checked to ensure medication was stored at the correct temperature so that it remained effective. We saw there were individual Medication Administration Record (MAR) charts which included a photograph of the person to assist with identification. We found these records were all signed appropriately by staff. We also reviewed a sample of medication described as 'controlled' or CD's. We found these records were incorrect for one person in that the records and the actual medication did not balance. We asked the manager to take appropriate action about this as part of our feedback at the inspection. However, we did not receive this information including if the person had received their medication correctly.

When we looked around the home we saw that peoples' rooms were personalised and on the whole clean. We found that not every bed had a mattress cover to prevent liquids being absorbed by the mattress. The registered manager fedback that only 35% of the people who lived in the home required this type of mattress cover. Additionally we found some flooring adjacent to sinks was damaged. This meant that any spillages would be able to leak under the flooring. In different rooms we found there was scuffed paintwork on the door frame, dust on a bed frame, and a plastic 'skirt' round the basin to hide the pipework was stained.

We also found concerns with toilets, bathrooms and the laundry rooms. These concerns included; paper peeling off the walls, a gap in the lino at the back of the toilet making it impossible to clean, and a bathroom used for storage. We also noted there was a lack of hand wash facilities, open bins, a dirty grab rail and plastic tiles peeling off a bath. We saw a toilet brush in use which was broken and meant a person would have to put their hand almost down the toilet when cleaning, a lack of toilet roll holders and a cluster of razors. It was unclear whether the razors belonged to one or several people.

In the staff toilet there was a notice which said, "Now wash your hands" with detailed instructions to prevent cross infection. However, there were no paper towels and no soap dispenser. The hand towels were standard terry towels. At the rear of the sink there was a pile of toothbrushes and it was unclear who these belonged to.

In the downstairs laundry drying room we found there was mould on the walls and ceiling, the floor was cracked, and plugs on extension leads over the top of the door for both dryers. There was a notice on the laundry door stating "Keep shut at all times" but we found this to be open. This meant people in the home or visitors could have walked

Requires improvement

Is the service safe?

into the laundry room and this left people at risk of harm. We saw there was no container for soiled clothes so these were stored on the floor and there were no facilities for staff to wash their hands. This included no hand gel or wipes. When we discussed the laundry facilities with the manager she explained that plans were currently being discussed to extend the laundry facilities. However, the current system did not support good hygiene practices.

We also found some concerns in the communal areas of the home. Areas on the upstairs landing were also used for storage these included a bed laid on its side, wheelchairs, a stand aid, a vacuum cleaner and a bag of equipment. Items did not appear to be obstructing the walkaway these made the area look untidy and less homely. In one area of the home the carpet was 'lifting' from the floor and in another the carpet was stained and uneven. This created a trip hazard.

When we looked in the kitchen we found there was a waste bin with no lid attached and the hand sanitizer and paper hand towel holder were broken. We saw that, although fridge temperatures were recorded, not all items in the fridge had the date recorded on them when they were opened, to help make sure food products were used within a safe timescale.

When we spoke with the domestic staff they told us they were up to date with training including infection control and Control of Substances Hazardous to Health (COSHH). They told us about their daily and weekly routines which included a 'Deep clean 'of people's rooms. The manager told us that each bedroom in the home would receive a deep clean at a maximum of a 10 day cycle. We saw that these staff signed to confirm the cleaning undertaken each day.

This was in breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. You can see what action we have asked the provider to take at the back of this report.

Requires improvement

Is the service effective?

Our findings

We observed people eating their meals both in their own rooms and in the dining areas of the home. People told us, "Some food's good and some food's not so good" and when asked if they had a choice of meals they said "No, they just bring it." We then asked if the person was able to have their favourite food and they replied "Don't think you have to have a favourite, you have to have what you're given."

However, we did observe the cook asking people what they wanted to eat and a relative confirmed this took place. Another person living in the home said, "They try to accommodate you as best they can". Speaking about the cook they said, "I say to her I can't chew that, she'll give you something else that I can manage." Another person commented that the food was good and she was enjoying the pudding.

One relative told us that a set of their relative's false teeth had gone missing. This meant it was difficult for her to eat food which required chewing. They said "She loves a cup of tea and a biscuit in the morning, at the moment she's nibbling like a rabbit to try and get the food swallowed." The relative told us the teeth had been missing for three weeks and the home was arranging some replacement teeth.

One professional told us people received a varied menu.

We observed the support staff offered at lunchtime in the main dining room. This appeared to be a very busy time for staff and we saw they did not have time to spend with people and support them. We saw staff bring peoples meals and ask if they required ketchup with their meal. However, staff did not inform people what their meal was.

One lady struggled to eat her meal. She asked staff for support and they said they would return. The staff member did not go back and support the lady and she ate what she could of her main course with her fingers, leaving the peas. The manager did support the person with eating her pudding but stood above the person to undertake this support, rather than sitting next to her. The original member of staff sat completing paperwork.

This was in breach of regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. You can see the actions we have asked the provider to take at the back of this report.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. The manager told us she had submitted several applications to request DoLS authorisations to the local authority and that a professional had begun to review these.

When we spoke with staff they had some awareness of MCA and DoLS and when prompted they were more confident in their answers. None of the staff spoken with were aware if anyone living in the home had been assessed as to their capacity to make decisions. However, one member of staff did comment about one person who lived in the home and said "She likes to walk upstairs, we can't tell her not to walk, and she still has her mental capacity to make decisions."

The medication policy included a section regarding 'covert 'medication which is when a person is administered medication without them being aware of this. The policy did not include that the person must be first assessed as not having the capacity to decide if they wished to take the medication and that a best interest meeting would need to be held to make the decision about the administration of the medication. A best interest meeting would involve representatives of the person, who would make the decision in the person's best interest. However, the manager did confirm to us that no one currently living in the home received covert medication.

We also saw a file which contained details of medical decisions that had been made with or for people. We noted that sometimes sections of these were dated 2 years prior and also that in one instance it was recorded the person did not have capacity to decide upon the intervention. However, there were no records of a best interest meeting being held.

One person had been identified as lacking capacity to make their own decisions and a best interest meeting had

been held to assist with decision making. However, the meeting had only been attended by staff working in the home and there was no independent representative for the person.

We recommend the provider review the latest guidance on the MCA, DoLS and best interest decisions.

When we asked one relative about staff skills they were unsure and commented, “I don’t know, they seem to know how to talk to her, they say, ‘Can you just put your arms on the sides’. I worry that she’ll slip down the chair”.

Staff told us about the training they had undertaken. They told us they received regular updates and their training files included evidence of this, including evidence of regular updates in safeguarding and manual handling training. We also saw that the manager completed a matrix to record staff training. This provided an oversight of what training had been undertaken and what remained outstanding. When we looked at the training matrix on the wall of the manager’s office we saw it recorded training in MCA was due to take place on the day of the inspection. When we discussed this with the manager, she said that it wasn’t taking place as the training company had ‘let her down’.

We asked the manager about specific training for supporting people with dementia needs. The manager told us they had completed dementia care training but had not completed any further training to be aware of latest best practice guidance for people with dementia needs. We asked staff whether they had any specialist knowledge in dementia care. One staff member told us, “I’m interested in it but have very little knowledge of dementia”.

We asked the manager if there had been any changes to the environment to support people with dementia needs, such as signage or the use of bright colours to help people identify areas of the home. The manager confirmed they had not undertaken any changes to the environment to support people with these needs and had not accessed professional specialist advice regarding this. We saw there were signs but these were difficult to read due to their height and being printed in a small font.

We recommend the provider accesses best practice guidance for supporting people with dementia needs.

Each staff member had an employee starter pack which included induction information. Some of the documentation had not been ‘signed off’ by the manager or the employee. We discussed this with the manager who explained that the filing system and all other administration processes were being reorganised and updated and that they would all be audited to ensure that the gaps were addressed.

Staff also told us they had received one to one supervision to help and support them with their role. We saw records of staff appraisals and supervision sessions which recorded staff had received this support throughout the year.

Professionals told us the home sought advice appropriately and were receptive to information and advice. We were told "They contact us in a timely manner", "They correctly identify patients who are unwell and seek advice appropriately" and " Staff have welcomed interventions from other professionals."

People’s files included details of their health needs and visits from professionals such as the GP, chiropodist or optician. This indicated that health care professionals were contacted when people needed medical advice or treatment. People also had patient passports in place. These documents summarise the person’s health and personal needs and wishes. They can be shared with other professionals, for example, if the person is admitted to hospital.

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Requires improvement

Is the service caring?

Our findings

We asked people who lived in the home if they felt they were treated with respect. One person said “Yes” and another person said, “They ask you what you want, they keep the rooms clean and change the bedding regularly, they’re very good, they do the best for me”. We also asked if staff respected the person’s privacy and were told “I’m very fortunate, I’ve got my own toilet, I’m not a prude to that extent. I can talk to the staff; generally speaking we’re looked after”. Another person told us staff didn’t respect them they said ““Not always, I get back-chat sometimes.” When asked what staff said, they told us staff said “We don’t want you in here, you’ll have to go.”

Professionals told us they felt the manager and staff were respectful and polite, they said of the manager and senior carer " They really know the residents", " Are appropriately affectionate and attentive" "They manage our patients with dementia very sensitively" and "Helpful and caring." One professional felt staff had got to know one person living in the home as "an individual" and another said " I feel staff are caring."

Staff told us how they supported people with privacy and this included that they “Always closed the door and curtains when providing personal care” and “In the shared room, always pulled the curtain round the bed to ensure privacy.” One member of staff said “I’d take them into their room, close the door, and put towels over them.”

One person who lived in the home told us they decided what time to get up in a morning. They said “I like to be up by a quarter to six, I get up myself.”

We arrived at the home at 6 am as we had received a concern that people were being assisted to get up early in a morning. When we arrived there were seven people up and dressed. Five of the seven people were sat in the lounge and two in their own rooms. When we looked at peoples care plans and daily diary notes we saw that some people regularly got up this early but this was not always the case. However, there was no information to record whether it was the person’s choice to get up early in a morning. Without this information it was unclear whether the decision to get up early had been made by the individual or the staff team.

We discussed with staff how people were supported to make choices particularly when people may have limited capacity. One carer said of a particular person “We always ask her, she is able to make choices, we always ask her but we know how she likes her cup of tea” Other comments included “(The person) likes to stay in bed until 10.30 am.”;”(The person) likes to be one of the first to get up” and “(The person) is diabetic and likes to have marmalade and bread with tea at 6.00 to control her blood sugar, she self-administers her medication.”

Staff told us about the role of a key worker. They said “I bring him in shaving stuff, aftershave, and blades. His family don’t see him much. I used to take him out for meals.”

We saw people’s toiletries and topical creams with their names were stored in the downstairs bathroom. This did not respect their privacy.

The manager told us no--one in the home was supported by an advocate. An advocate is someone who is independent and will speak up for the person when they are unable to do so themselves.

The manager told us staff treated people like part of the family and ‘go the extra mile’. We observed interactions between staff and people who lived in the home were positive. However at times, particularly lunch times, these were brief as staff appeared to be rushed. Additionally, staff had no time to sit and spend time chatting or undertaking activities with people.

Requires improvement

Is the service responsive?

Our findings

When we spoke with relatives they told us, "I've never been involved in discussing the plan of care. When it's nice, we sit outside. I've taken her out in the chair. She has her hair done once a week and her feet done." One relative said, "They do have bingo sessions and quizzes, she sits in her room and watches TV". Another relative said, "They sometimes go off to the market when the weather's better.

The manager told us there was an activities person employed in the home three days per week from 10:00 until 17:00. The activities that were available to people included movement to music, card games and bingo. In addition a local museum was visiting the home. The manager also told us how people who lived in the home were able to access events in their local community and this included seasonal events, for example, an Easter bonnet parade.

During the visit we did not observe any activities take place. When we arrived at 6 am some people were sat in the main lounge watching the television. The television remained on all day and it was unclear if this was being watched. We did not see people being asked what they would like to watch. People who spent time in their own rooms could choose to have the television on. The TV in the main communal area seemed to be on but no one was watching it or knew what was on.

Some people had visitors during the day and some people left the room. However, other people relied on staff to be able to leave the room. As staff were busy some people sat for long periods of time. Staff appeared to be busy and not available for people in the lounge for periods of time. We asked one man what he was watching at 11.00 and he said, "I think its breakfast television".

We looked at the records of activities people undertook in the home. We saw people were offered activities and if they declined an activity this was also recorded. This evidenced people were supported to choose what they wished to participate in. We also saw that at times it was recorded that people were 'unable' to participate in an activity. It was unclear if this was because the person was unwell and unable to participate or if the activity was not suitable for the person's needs. We saw activities included going out to the local market, a quiz, sing a long and glass painting. The manager also told us the vicar visited the home so people could participate in a religious service if they wished to. We saw no evidence of reminiscence type activities designed for people with dementia related needs. **We recommend** the provider reviews how people's leisure and social activity is met in the home.

People had individual care plan records which included a 'personal profile'. This document included some family history, for example, if the person was married and who their siblings were. This information was described in more detail in the persons 'life history', which provided information to staff to help them to get to know the person.

Peoples care plans included an assessment of their needs and the support they required. This included the social activity they preferred, any interests, religious needs, physical health needs and current medication. We found that information on how to support someone with the meeting of their need was not always detailed or clear.

Daily notes were also kept of how the person had spent their day. This included what time the person got up, what time they went to bed and the support they received. We saw for one person the notes recorded they got up at different times of the morning and this varied between 04:30 or 05:00 and 11:00. There was no information to record if this was the person's choice or if staff had decided this for the person.

There was a complaints policy held in the home which provided information on how people could make a complaint. The manager told us no complaints had been received in the home. We saw that the home had received three compliments in 2014.

Requires improvement

Is the service well-led?

Our findings

There was a registered manager in post at the home. A relative spoke positively about the manager. We asked what she would do if she had any concerns and she said "I talk to the manager, she's brilliant. I go straight to (person A) or (person B)." Another relative said, "The staff that I know, we can have a conversation about what's going on which is really good."

A professional told us they had a good working relationship with the home and felt the staff communicated effectively.

Staff were aware of the whistle blowing policy and said that they had never had a need to whistle blow but would have no hesitation in reporting anything if they had concerns.

Whilst we reviewed the medication systems and as part of our feedback to the manager we asked the manager to forward information in relation to a medication discrepancy in the home. This was not received.

We found that records within the home required improvement. This included risk assessments, care planning, and the medication policy.

We found that the registered person did not protect service users against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2)(d) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. You can see the actions we have asked the provider to take at the back of this report.

The manager told us there had been a 'service user' meeting held in the home in the last year but there had not been one this year. There were records of meetings in the home and the manager told us these were regarding activities only.

We saw records of a staff meeting which had recently taken place. The minutes recorded that the subjects covered included the needs of people who lived in the home, staff training and general issues in the home. These meetings helped to keep staff aware of any changes in the home and to be able to comment on these.

There was a quality assurance system in the home which included people who lived in the home completing questionnaires. The questionnaire responses included some concerns raised by people. For example, one person commented "Some staff better than others", "Buzzer not always available or answered immediately", "Younger staff talk to us as though we are children. I don't like it" and "I don't think there are enough staff."

Visitors and relatives were consulted through the use of questionnaires and some of this feedback was positive about the home.

The manager had completed a summary of the feedback from the questionnaires distributed to people who lived at the home and visitors / relatives. An action plan had been produced but there was no evidence that the concerns raided by people living in the home were responded to. It appeared that people's voices were not responded to when they raised negative comments about the home.

We saw some of the audits which were completed within the home. These included a medication audit which had been completed in December 2014 and January 2015. We saw evidence of maintenance checks completed within the home to help make sure the environment remained safe for people who lived there. This included weekly checks of the hot water temperature, checks of the gas systems, emergency lighting and stair lift. We also saw that records were kept of any maintenance undertaken within the home; this consisted of a list of repairs required and when these were completed.

Records were kept of all accidents that had occurred in the home. These recorded details about the person and the injury. However, we noted these did not include details of any follow up actions taken or review by the manager to help with learning and prevention of any future incidents.

However the quality assurance system was not effective as it had not identified the areas of improvement recorded in this report. This was in breach of regulation 10 (1(a)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and social care Act 2008 (Regulated Activities) regulations 2014. You can see the actions we have asked the provider to take at the back of this report.

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This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **We found that the registered person did not protect service users and others who were at risk of inappropriate or unsafe care and treatment by means of an effective system to regularly assess and monitor the quality of service provided.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **We found that the registered person did not protect service users from the identifiable risk of acquiring an infection.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **We found that the registered person did not protect service users from the risks of inadequate nutrition and dehydration.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **We found that the registered person did not protect service users against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered person did not take sufficient steps to safeguard people's health and welfare by ensuing there was at all times sufficient numbers of suitably qualified skilled and experienced persons employed in the home.