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Ashmeadows

Inspection report

Moorbottom
Cleckheaton
West Yorkshire
BD19 6AD

Date of inspection visit:
17 December 2015

Date of publication:
06 September 2016

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

The inspection took place on 17 December 2015 and was unannounced. There were two adult social care inspectors. The home was last inspected in 2013 and was compliant with regulations at that time.

Ashmeadows is a small care home that was formally the local vicarage, situated next to the local church. It has a capacity to accommodate 17 residents in 13 single rooms and two shared rooms; eight have ensuite facilities with a toilet and wash basin. On the day we visited there were 12 people who lived at the home.

There was a registered manager at the service. 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.

We found the home had an open and friendly atmosphere, but on further inspection during our tour of the building we found significant concerns with the premises and equipment. These included electrical safety and fire safety and we asked the fire officer to make a visit following our inspection. The fire officer made several recommendations to ensure the safety of people in the home.

Staffing levels were not always sufficient to meet the dependency needs of the people in the home and staff training was not up to date.

Systems and processes to manage medications were not robust.

Staff were kind and caring and there were good relationships with people.

There was teamwork within the home and through working with other professionals involved in people's care. However, referrals were not always made to other professionals where people's needs changes, such as for needed specialist seating.

Care documentation was up to date and in place, although lacked detail and was not discussed with people so they could be involved in their care and support.

There were limited activities for people to be meaningfully engaged.

Systems for assessing and monitoring the quality of the provision were not robust and although identified areas of concern highlighted by the inspection, there had been little done to secure improvement.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Premises and equipment were not safely checked or adequately clean to make sure risks to people were minimised.

Staffing levels were not always effective to meet the dependency needs of the people.

The arrangements for medicines management was not safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training was not all up to date.

There were positive relationships with other professionals where they were involved in people's health care.

People enjoyed the food and staff ensured there was continuous access to food and drinks.

Is the service caring?

Requires Improvement

The service was caring, but staff were not able to communicate effectively with a person for whom English was not their first language.

People said they felt well cared for.

There was evidence of positive caring relationships between staff and people in the home.

People's dignity and privacy was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not have sufficient opportunities for meaningful activity.

People knew how to complain although available information about the complaints procedure was limited.

Care records were up to date, although not discussed with people and detail was not always clear or specific enough for staff to meet particular aspects of their care needs.

Is the service well-led?

Inadequate

The service was not well led.

Although there were quality assurances systems in place these were ineffective to monitor and improve the quality of the provision.

Where the registered manager was aware of weaknesses in the provision, insufficient action was taken to drive improvement.

There was a culture of openness and transparency and the registered manager was regarded well by staff, people and visitors.

Ashmeadows

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 17 December 2015 and was unannounced.

The inspection team consisted of two adult social care inspectors.

There were 12 people living in the home at the time of our inspection. We spoke with 6 people who lived at the home and three relatives. We spoke with two staff, the registered manager and the regional manager.

We looked at four care records. We also saw other documentation showing how the home assessed the quality of care including accidents and incidents, maintenance logs and audits done within the home and by the organisation.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe. One person said: "Well I certainly feel safe here, I wouldn't stay here if I didn't". Another person said: "Yes the girls [staff] make sure I'm safe, they keep an eye on me".

However we had some concerns about the safety of the premises and equipment. We noted that there was only one small domestic bin for the disposal waste outside and that the overflow in plastic bags was on the driveway. The registered manager told us that the bin was too small for the home's waste disposal needs.

There were two bathrooms with toilets on the first floor. One bathroom was also designated as a sluicing area but was in use as a bathroom by some people. The other toilet and bathroom could be accessed only by those who were physically able enough to mount a steep step. Yellow and black adhesive tape defined the step but this was peeling off and worn. There was a specialist bath which we found was broken and dirty and which staff told us was never used.

We inspected some people's bedrooms with a member of care staff to determine how people could access a bedside light or a drink during the night. We found a number of people would have particular difficulties as their beds were not situated near lighting or any bedside table from which they could reach a drink. Again we found numerous problems with the electrical supply and the overuse of extension leads, such as where people had specialist electrical beds. Also we were told that one person's bedside light could not be turned off and that another person had to have the ensuite bathroom light on all night so that staff could complete their two hourly safety checks.

We saw there were a lot of miscellaneous items stored in communal areas, on stairs and in areas that were designated fire escape routes. In the basement we saw the fire escape was a window which we had difficulty opening and closing. There was a long corridor linking all the other rooms in the basement. It had no light as the bulb had not been changed and staff were unable to explain how long the corridor had been unlit. We also found the electrical wiring for lighting to parts of the basement to be unsatisfactory. For example wires were run from electrical points and pinned on the outside of the walls and the lights run from them were inspection lights. In addition we found the cleaning buckets and mops stored in this corridor just before another room which had no satisfactory lighting. This was used as the storeroom for cleaning products. We found the Control of Substances Hazardous to Health (COSHH) store cupboard open despite having a lock on the door. At the end of the corridor was a large storeroom completely packed with black plastic bags which we were told came from a house clearance. When asked when they would be removed, staff were unable to confirm. The store was dirty and a state of complete chaos. There were three broken vacuum cleaners, one of which we were told was to be kept as a backup and we noted that the electric cord was held together with adhesive tape. There were also numerous boxes of incontinence supplies and two large freezers used to store frozen food. It was difficult to access these due to the way in which the contents of the house clearance and the boxes of supplies had been scattered about the room. Indeed as we in attempting to inspect the freezers we found a box of chocolate logs stored on the floor.

On the first floor there was a bedroom undergoing refurbishment which contained various items such as a

upended bed and some ladders, yet this room had two fire doors and these were both obstructed by the items in the room. There were disused items extensively stored in an ad hoc manner in one of the attics. There were also Christmas fairy lights displayed around the home powered via extension cables and sockets.

The registered manager told us six staff had not received training in fire safety. Staff told us they had not undertaken a practice of fire evacuation and we received conflicting information related to the assembly point for the home.

We saw some equipment, such as the hood drier for the hairdresser's use, appeared to be very old and we saw it had not had a portable appliance electrical safety test (PAT) since 2013. We also found a portable electric heater plugged in to the electricity by a three-way adapter. We tested the heater and found when in use it would cause serious risk of burning to anyone who touched it and we therefore removed it from use and gave it to the manager for their attention. We contacted the fire officer with our concerns and they agreed to make a visit immediately following our inspection. Following their visit the fire officer told us they requested the provider take immediate action to rectify areas of concern throughout the premises.

We found the kitchen to be in serious need of repair. There were no cupboard drawers. Several cupboard doors were missing and the dishwasher was broken. Electrical equipment was stored there that staff could not account for and was not electrically tested as were other electrical items which were in everyday use. A broken oven had not been removed. The insect and fly catcher machine required servicing and electrical wiring was again unsafe with wires running from sockets using three-way adapters tacked to the walls and being run to the pantry where another electrical extension lead was being used to run a spare fridge. Thermometers were missing from the freezers; there was no record of when the freezers had been defrosted so that those in the basement were overstocked and dripping water and the bread freezer temperature was not monitored. We saw the washing machine flooded the basement during the inspection.

We saw there were windows that had no suitable restrictors to prevent the risk of falling and there were no robust risk assessments in place to ensure people's safety. There was no restrictor on the manger's attic office window despite there being one person living at the home who was at high risk and mobile enough to use the open stairwell. We saw a large tear in the floor covering in the dining area which may have been a trip hazard.

We saw furniture was not always suitable for people. For example, one person whose abilities had changed since falling, had poor posture and the seat they were using was not supportive, with their neck frequently in an awkward position. We spoke with the registered manager who told us the person had not been referred for any specialist seating or equipment and agreed this was something they could arrange.

This meant the provider was in breach of in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12(2)(b)(c) as they were not doing all that was reasonably practicable to mitigate risks to the health and safety of service users. The provider was also in breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014,regulation 15 as premises and equipment were not properly maintained.

Staff we spoke with told us they knew the procedures for reporting any concerns about a person's well being and would be alert to the signs of possible abuse. Staff said they were confident the registered manager would deal promptly with any allegations or suspicions of abuse to ensure people were safeguarded, although staff knew who to contact should concerns not be referred appropriately.

Individual risks assessments for people were not always implemented. For example, where care plans identified one person needed a walking frame we saw this was not used in practice. One person we saw needed a hoist to enable staff to transfer them in and out of their chair or bed. Staff told us there was only one sling for use with the hoist in the home. Staff said this sling was washed overnight but should the person require assistance with moving and handling whilst the sling was being washed they would have to wait.

We reviewed the accidents and incidents records with the manager and found there was no ongoing analysis of the accidents and incidents within the home. We asked the registered manager to undertake this and send a copy to the lead inspector. We saw numbers of accidents and incidents were noted on the manager's monthly audits, although there was no evidence that any trends and patterns had been identified to plan for future learning. There were a significant number of and witnessed repeated incidents for some people.

The staffing levels during the day were insufficient to meet the dependency needs of the people who lived at the home. We reviewed a four week staffing rota which clearly demonstrated that there were only two carers on duty to care for the people during the day and night. There was a bank carer available to provide flexible cover either for days or nights. We saw when two staff were busy with one person, for instance assisting with moving and handling, then there was no available staff to attend to the other people's needs. It also meant that staff were unable to have a 30 minute uninterrupted break during their 12 hour shift. We also noted that there was no designated room that was solely for the use of staff within the home. Staff confirmed that there were not enough staff and that they did not always take their breaks. One member of staff said "We can't always be in two places at once", but they also said they 'loved it here and 'love their job'.

There was not always a manager present at the home as the registered manager worked an eight-hour shift and was not always available to offer practical support. We noted that the registered manager was unavailable for all of the Christmas and New Year holiday period and there was no cleaning service provided as the cleaner was being deployed as a carer at that time.

The people who lived at the home complained to us that there were not enough staff to provide the care they wanted. One person told us they had wanted a shower during the day but had been told that this could be only given to them by the night staff. They told us that this was not what they wanted as if they took a shower that late they would go to bed "all hot and sticky and not sleep well".

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 18(1) because there were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed.

We saw medication was stored safely and appropriately documented for ordering, administering and disposal. However, medicines were stored within the staff room which was also used store the vacuum cleaner, iron and ironing board for domestic use. Medication administration charts were completed for each person and there was a system in place to ensure controlled drugs were stored separately and signed for by two staff. However we saw people were not always supported to take their medication appropriately and explanations were not always given to ensure people knew what their medication was for. For example, one person was given two containers, one with liquid and the other with eight pills. The member of staff walked away and we sat with the person who played with their tablets for ten minutes and questioned what these were for. When staff walked past the person asked what these tablets were for, staff said they did not know. The person was again left with their tablets alone. We asked staff if it was usual practice to leave people with their medication and staff said it was not.

We spoke with staff about the safe keeping of keys to the medication store. Staff told us they left the keys under the cover of the medication record file until the following day shift, as no staff who currently worked nights were trained to give medication. Staff said that if people had any pain in the night, pain relief could not be administered by night staff and the on-call staff would need to be contacted. Staff also said that one person needed time critical medication at 6am and this was handed to the night staff to give, but then signed for by the day staff coming on duty. This meant that day staff were signing for medication that they had not given and night staff were giving medication when they were not trained to do so.

We were told the local pharmacy carried out the medicines management training. However, the competency assessments reviews were not scheduled on the training matrix and staff had not been reassessed. There was no evidence of NICE guidelines relating to the management of medicines for care homes being used to guide practice within the home. The manager was advised to consider using the information provided in these guidelines in order to carry out their annual competency reassessments.

The above examples illustrate a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12(2)(f) because systems for managing medicines were not safe.

We saw areas of the home were not cleaned effectively and staff did not always have due regard for infection control procedures. One member of the care staff was wearing nail extensions and glitter varnish although they were aware that they ought not to when providing personal care. We noted from the training matrix that staff had not had updated infection control training.

We were told only one member of staff was employed to provide domestic services and though they were trained in care, had not received training for their current role. We found supplies of hand washing equipment were not adequately maintained nor were cleaning equipment and solutions safely used. For instance staff had not received any COSHH training and had no safety datasheets for the solutions they were using. There was no scheduled cleaning, solutions including bleach were kept and carried round the home in a bucket. Staff used separate coloured cleaning cloths for surfaces, sinks and toilets.

The mop heads we saw in use in the kitchen and those in the basement were visibly very dirty. When asked staff did not have sufficient supplies or a procedure in place to ensure they were fit for purpose. We asked that all the mop heads be changed and advised staff to wear appropriate hand protection when handling chemicals. There were no laundry containers for staff to put dirty laundry in when changing beds. The provider was unable to demonstrate they complied with guidance from the Department of Health about the prevention and control of infections: Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

The above examples illustrate a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 15(2) because systems for ensuring hygiene and cleanliness were not maintained.

Requires Improvement

Is the service effective?

Our findings

People told us they thought staff were competent in their role. One person said: "They must know what they're doing or why would they be here?". Another person said: "It's not an easy job, I understand that, and they do it well". We spoke with relatives who said they felt staff knew their family members well and were able to respond to their needs.

Staff training was not up to date and the registered manager told us this was an action they hoped to address. Staff said they felt supported to undertake training. We found most of the care and kitchen staff had nationally recognised training in care and catering. However the essential training identified by the provider in order to enable staff to maintain their skills and carry out carry out their responsibilities safely and effectively was not being maintained, such as in relation to mental capacity and dementia. This meant people were at risk of being cared for by people who are not appropriately trained to deliver the services required.

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. We found that staff had not received training or updated direction in relation to The Mental Capacity Act and Deprivation of Liberties Safeguards despite having people who lived at the home who had an order in place. Staff we spoke with had some understanding of mental capacity although they were unclear how many people in the home lacked capacity to make particular decisions and told us 'quite a few'. We saw in people's care plans their mental capacity had been assessed and one person had a deprivation of liberty safeguard (DoLS) in place.

The registered manager told us there was no supervision policy, although we did see evidence of some supervision records and noted that staff had received at least one supervision session in the last year. The format used by the manager to guide these supervision sessions was useful and had been completed effectively by the manager. Where disciplinary action was considered this was recorded. However no follow up had been recorded or undertaken on any of the supervisions.

We noted that there had only been eight appraisals are undertaken in the last year. The failure to schedule and undertake regular supervision and appraisal, or follow up on those that had been undertaken mean that staff are not given the guidance and direction they require in to understand what is expected of them in their various roles.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 18(1) (2)(a)because there were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed and staff did not receive sufficient support, training and professional development.

As we arrived to undertake our inspection, the local supermarket was delivering an order. We noted some of the supplies particularly fresh meats had been left on the floor of the dining room near to the kitchen. In addition to this we had a number of concerns related to stock control and the effective monitoring and recording of food storage and preparation. For instance, there were cakes ready for use in storage containers but with no date to say when they had been prepared. Dry goods had been decanted into large storage containers with no date as to when this had occurred or when they were out of date. Thermometers were missing from the freezers, there was no record of when the freezers had been defrosted so that those in the basement were overstocked and dripping water and the bread freezer temperature was not monitored.

People told us they enjoyed the meals and we saw mealtimes were social occasions with plenty of conversation in a relaxed and friendly way. One person said "The food here is grand" and another person said "We always have plenty eat, we're always eating". People said the food was 'one of the good things' about living in the home. The staff agreed that the food was good and generally of good quality. We saw the menus for four weeks which demonstrated that the home provided a range of nutritious food. The kitchen staff told us that they did not have a list of peoples likes or dislikes but that they asked people on the day what they would like to eat and they adapted the special diet that one person needed depending upon their needs that day.

We saw fruit bowls were full and people could access these at any time. Drinks were accessible to people or visible in jugs for people to indicate what they would like. We heard staff regularly offered drinks to people, and where people wanted something in particular staff obliged. For example, one person asked for a particular warm drink and staff brought this for them.

Staff told us none of the people were being monitored for weight loss although they had good links with the dietician should they need to refer anyone or seek advice.
We spoke with a visiting GP who told us they were not aware of any concerns about the home. We observed communications with the district nurse were productive and there was evidence of effective professional relationships to ensure people's health care needs were met.

Requires Improvement

Is the service caring?

Our findings

We found Ashmeadows was very friendly, welcoming and homely. People were content and at ease and told us they were happy living at the home. One person said "I know I can't look after myself and that's why I'm here. It's not like my home but it's the next best thing". Another person said "The staff are lovely and nothing is too much trouble. I can have a laugh with them, they're good 'uns". One person told us they had difficulty with their vision and staff supported them in 'the most caring manner' without compromising their independence. One relative we spoke with said staff extended their caring skills to people's families as well as people themselves.

Staff were very kind and patient with people and were observed to be open and considerate in their approach all times. Where people were confused or needing reassurance staff spent time with them and offered comforting words and appropriate touch, such as hand holding. Staff communicated with people and actively listened to what they said. They made eye contact and gave people time to speak and they listened patiently when people were speaking. When assisting people, staff used appropriate pace and reassured them throughout, such as when walking with people.

Staff were mindful of people's privacy and dignity. They knocked on people's doors and were discreet when offering assistance with personal care or when moving and handling people. There was evidence of positive relationships and a good rapport between staff and people living in the home.

We were told by staff that there were no people with any particular cultural or social needs, however we found that where people were unable to communicate verbally their needs were not always met. Staff told us they communicated using gestures and facial expressions, although this was limited in ensuring people's needs were fully understood and met.

This showed the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 10 (2) because the diverse needs of all the people were not fully considered.

Staff knew which people had relatives and those that did not. Where people needed an advocate to assist them this was arranged and noted on people's care records.

Requires Improvement

Is the service responsive?

Our findings

People told us they would like more activities. Some people said they were bored. One person told us: "There's nowt happening really. Sometimes we get a singer but not all the time". One person told us they did not watch the television even though it was playing. We heard and saw one person played a musical instrument and staff supported them well with this. However for those people who wished to watch television, the sound of the instrument played over the sound of the television. One person told us: "There's not much going on" and said "I prefer to listen to my radio and music in my room". The home was decorated for Christmas but with only two care staff during the day the opportunities to provide for people's social interaction were clearly limited. We observed a number of people spent their time in front of the television.

The home had no activities coordinator and the registered manager could not show us a current list of planned activities for the people who lived at the home, although the service user guide states user guide stated 'a programme of activities is run daily'. We saw the latest activities list was dated October 2015. One person said there had been a dominoes competition but 'not for a while' and we saw this was dated November 2015. There was a key worker system in place although when we asked staff the details related to the people they were unable to recall the essential personal and care information that could be expected of someone delivering person centred care. The care we observed was mostly task focused due to staffing levels.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 9 because the care and treatment of people did not meet their needs or reflect their preferences.

We were told that the care staff were responsible for completing the care plans and the monthly reviews. We saw care plans and reviews were up to date, although there was little evidence these had been done in consultation with people and the care plans we looked at were not always clear in the instruction to staff. For example, information about personal care, well being and skin integrity was in place but the sections were merged together, making it impossible to pick out relevant information. People's particular mobility needs were identified although there was limited information for staff to know precisely how to move and handle a person.

There was a complaints policy and procedure which also had information in alternative easy to read format which we saw in the files kept by the registered manager, but these were not in use in the home. The information that related to complaints in the service user guide was sparse and consisted of five lines of information which did not provide sufficient detail on how to complain nor the procedure to follow. The registered manager told us that they had received no complaints during the last two years. During our examination of the records and discussions with people who lived at the home and staff we found they had in fact been several complaints. For instance, we found two raised during supervision meetings and not recorded and others raised by people who lived at the home and their relative that had not been taken seriously. We found that there was no proactive approach by either the registered manager or staff in

ensuring concerns and complaints were recorded, dealt with effectively and within an appropriate timescale. This meant staff and management were unable to identify points for future learning.

People told us they knew who to tell if they had a complaint or were unhappy about something. People and relatives said they would speak with the registered manager and found them to be approachable. One relative said they would not have any reason to complain but would not hesitate to find the registered manager or any of the staff and discuss any concerns with them.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post who was registered with the Care Quality Commission. People told us they thought the registered manager was visible and proactive in the service. One person said: "[The registered manager] is lovely, she runs the place well". Another person said: "[The registered manager] is usually around and about".

There was evidence of good teamwork and staff had direction in their work. We saw staff pulled together to help one another and were flexible. For example when care staff noticed ancillary staff needed help with attending to a flood in the laundry they joined in to offer support. Staff reported high morale and said they enjoyed working in the home.

The atmosphere in the home was warm and welcoming and the registered manager was experienced and well liked by staff and visitors. Staff said they found the registered manager to be supportive of them in their roles. However staff said they did not feel fully supported by the wider organisation. We found the registered manager was not successful when dealing with the provider to resolve their ongoing quality problems they were aware of within the home. They were not proactive in ensuring that staff had the vital resources and support they needed to undertake their caring responsibilities. Although the registered manager had monthly meetings with their manager and received verbal feedback they had no written record of these meetings to demonstrate that the provider was aware of their concerns.
Whilst we saw evidence of numerous maintenance issues and training issues raised by the manager in their weekly occupancy reports, we did not see a list of these issues recorded, nor the dates reported, the reply and date from the provider or the date on which any problems had been resolved. Consequently numerous significant problems related to the environment, repairs, purchasing of equipment and staffing remained unresolved. In addition, staff were not aware of when broken equipment could be expected to be repaired, or when items, such as discarded broken equipment would be removed.

The registered manager showed us evidence of environmental audits and an external health and safety inspection report and other monitoring audits that were undertaken. We saw there were many ticks in tick boxes and spaces for comments, but we found they were not identifying the reality of the situation within the home and an unrealistic impression of the quality of the service was being portrayed. For example, the format for the comprehensive home checks used categories such as yes/ no/ partial or n/a; when completing the form the manager responded yes to all staff have received training when they had not and yes to kitchen staff monitor special diets and identify all diets for individuals when they did not.

We saw records of environmental and equipment safety checks such as lift, water and gas, but this was incomplete. For example, there was no list of equipment that required electrical PAT (portable appliance testing) or the renewal dates meaning that some equipment was not tested for safety. There was no record of when the electrically operated beds were serviced.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 17 (2)(a) because there were significant weaknesses in the systems

and processes in place to monitor and improve the quality of the service.

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 9 HSCA RA Regulations 2014 Person-centred care People's care was not person centred; not all people could access a bath if they wanted one and there were limited meaningful activities for people in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's diverse needs were not fully considered or met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not sufficient to meet people's needs and staff training was not up to date.

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 People's safety was not well managed in relation to fire safety, premises, equipment and poor risk assessments.

The enforcement action we took:

Issued warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises and equipment were not safe in relation to buildings and fire safety

The enforcement action we took:

Issued warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor and improve the quality of the provision were not effective.

The enforcement action we took:

Issued warning notice