Devaglade Limited

Aaron View Care Home

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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out this inspection on 4 and 8 March 2016. The inspection was unannounced, which meant the people living at Aaron View and the staff working there didn't know we were visiting.
The home is registered to provide accommodation and care for up to 30 people. Bedrooms are located on both the ground floor and first floor level with stair and lift access. On the days of our inspection there were 22 people living at Aaron View.

Our last inspection at Aaron View took place on 16 June 2014. The home was found to be meeting the requirements of the regulations we inspected at that time.

It is a condition of registration with the Care Quality Commission that there is a registered manager in place. 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. There had not been a registered manager at the service since January 2016 and the provider was in the process of recruiting a replacement. The deputy manager, who was temporarily covering the manager's post was present during both days of our inspection.

People told us they liked living at Aaron View.

We saw that people's medicines were stored safely and securely, and procedures were followed to ensure that people were given the correct medicines at the right time. One person told us, "They [staff] are very good here. They make sure I get my tablets right."

Staff we spoke with understood what it meant to safeguard vulnerable people from abuse, and they were confident management would take any concerns they had seriously and take appropriate action.

Care records were not up to date or readily accessible to staff. There was no evidence to suggest that people or their relatives were involved in any reviews of their care needs. The manager and the provider did tell us they were reviewing and updating all care records.

We saw there were not enough staff available to care for people adequately and to meet all of their needs. People confirmed they would like to have more baths or showers than they were currently able to. Staff were rushed when serving dinner.

There was a part time activities coordinator employed at Aaron View, however some of their time was taken up caring for people. There was no programme of activities available. Both the people living at Aaron View and the staff working there told us they would like more activities to be available to people.

There was no complaints policy on display, however the manager had recently introduced a system to

record any complaints and what action, if any was taken to resolve the concerns raised.

People who lived at Aaron View and the staff that worked there told us the manager was approachable and supportive.

There were no systems in place to monitor and improve the quality of the service provided. There had not been a residents or relatives meeting in the last 12 months. This would have given people and their relatives the opportunity, in a formal way, to provide their opinion of the quality of the service provided. Regular checks and audits in some areas, such as medication were not undertaken to make sure the policies and procedures in place were properly followed.

All of the service's policies and procedures were out of date. None had been reviewed since September 2010 and therefore may no longer reflect current legislation practice guidelines.

During our inspection, we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to staffing, person centred care and good governance. 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?

Requires Improvement

The service was not always safe.

There were not enough staff to meet the needs of everyone living at Aaron View in a timely way.

We found systems were in place to make sure people received their medicines safely and that they were stored securely.

Staff told us they had safeguarding training and understood what they needed to do to if they suspected a person may have been abused.

Staff recruitment procedures were followed, which meant that people were cared for by suitably qualified staff who had been assessed as safe to work with people.

Is the service effective?

Requires Improvement

The service was not always effective.

People told us they liked the food served at Aaron View, but there were limited choices available to them.

The frequency of staff supervision was variable, however all staff had an appraisal in the last year.

Staff were provided with training to undertake their jobs effectively.

The service acted in accordance with the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) guidelines.

Is the service caring?

Good

The service was caring.

People told us that the staff working at Aaron View were caring.

We saw that staff respected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not responsive.

There was a part time activities coordinator employed, however the programme of activities was limited and did not meet the needs of everyone living at Aaron View, particularly those living with dementia.

Most care records were out of date and therefore did not reflect the person's current level of need.

There was no evidence to indicate that people or their relatives had been involved in reviews of their care records

The complaints policy was out of date and not displayed anywhere. The manager did keep a record of any complaints they received and any action taken to resolve them.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Some quality assurance audits were in place but were not undertaken regularly.

There were policies and procedures in place, however none of these had been reviewed since September 2010 and therefore may not reflect current guidance.

There had not been a meeting with residents and relatives for over a year to formally ascertain their views.

Aaron View Care Home

Detailed findings

Background to this inspection

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

We carried out the inspection on 4 and 8 March 2016 and it was unannounced. The inspection team was made up of two Adult Social Care Inspectors.

Prior to the inspection we reviewed the information we held about the service and the registered provider. This included notification of any incidents which may impact on service delivery and any injuries or alleged abuse sustained by people living at Aaron View. A notification should be sent to CQC every time a significant incident has taken place, for example where a person who uses the service experiences a serious injury.

We contacted staff at Healthwatch and they had undertaken an 'enter and view' visit on 1 May 2015. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Local Healthwatch representatives carry out 'enter and view' checks to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. We also met with members of Sheffield City Council Contracts and Commissioning Service who had no concerns regarding the service.

We used a number of different methods to help us understand the experiences of people who lived at the service. We spent time observing the daily life in the service including the care and support being delivered by all staff on duty. During the inspection we spoke with eight people living at Aaron View, two visitors, who were either relatives or friends of people living there, seven members of staff, including the manager and registered provider, and a visiting health professional.

We reviewed a wide range of records, including seven people's care records and three people's financial records. We looked at four staff files. We checked the medication administration records for four people receiving medicines at lunch time. We observed people having breakfast and lunch, and we observed part of a medicine administration round. We also reviewed the policies, procedures and audits relating to the

management and quality assurance of the service provided at Aaron View.

Requires Improvement

Is the service safe?

Our findings

When we asked people if they felt safe living at the home, one person living at Aaron View told us, "They [the staff] are very good here. They make sure I get my tablets right," and another person responded, "Yes, it's alright [living here]".

The medicine's policy was dated September 2010 and therefore over five years out of date. We spoke to the manager about this who explained that all staff responsible for medicines were given guidance to read followed by a written test to check that they had understood what they had read. In addition we were told staff also shadowed more experienced members of the team while they undertook this role.

We observed part of a medicines administration round at lunch time. We found the team leader for each shift was responsible for administering medicines. We saw people were offered a drink to take their medicines with and the member of staff stayed with the person until they were sure they had taken them. After this the member of staff signed the MAR (Medication Administration Records) chart to confirm the medicines had been taken. Some medicines are prescribed to be taken PRN, which means as and when required. For example, pain relief medicines can be prescribed in this way. We saw that these medicines were clearly labelled and staff signed to say when the person was offered PRN medicines, and if they had accepted them or not. We saw there was a copy of the signatures of the staff who were trained to administer medicines and this correlated with the signatures on the MAR charts. The MAR charts we saw did not have any missing signatures. This confirmed that these people were given the right medicines at the right time.

Some prescribed medicines are controlled under the Misuse of Drugs legislation and these are often referred to as controlled drugs (CD). These were stored separately in a locked cupboard in the manager's office. We checked the CD register and found it was fully completed, up to date and stock balances were accurate. We saw the medicine fridge contained appropriate items and was not overstocked. The fridge temperatures were recorded daily to ensure medicines were safely stored within the appropriate temperature range. The medicine trolley and fridge were stored in a small room next to the main living area. We saw this was locked when not in use. When the team leader was called away from the medicine trolley they locked the doors on it. This meant that medicines were stored safely and securely at Aaron View.

Staff told us and we saw in staff files that they received annual training regarding protecting vulnerable adults form abuse. Staff could describe the different types of abuse and were clear of the actions they should take if they suspected abuse. Staff said they would always report any concerns to the manager or senior person on duty and they felt confident that senior staff and management at the home would take their concerns seriously and take the appropriate action to help keep people safe. Information from the local authority and notifications received showed that procedures to keep people safe were followed.

Not all the staff we spoke to knew about whistleblowing procedures. Whistleblowing is one way in which a worker can report concerns, by telling their manager or someone they trust. The policy was dated September 2010 and therefore out of date. This meant staff were not aware of how to report any unsafe practice, bullying or harassment.

Most of the care records we looked at did not include up to date risk assessments for people's health and well-being, such as a falls risk assessment and a skin integrity assessment. None of these care records contained information for staff on what action to take to try and mitigate any identified risks. This meant care records did not describe the equipment and actions needed to keep people safe.

We saw that a fire drill had taken place within the last three months and that people had personal emergency evacuation plans in place. The manager had completed these themselves and they told us the fire officer had said they were acceptable. However, they were not signed or dated so we were unable to tell if they had been reviewed and therefore still meeting the person's fire safety needs.

The manager was responsible for managing small amounts of money for nearly everyone living at Aaron View. One person chose to manage their own money and was supported by their family to do this. The manager kept an individual financial record for each person who could access funds from a petty cash float. We checked the financial records and receipts for three people and found they detailed each transaction, the money deposited and the money withdrawn by the person. The records were signed and up to date. The manager told us and we saw that the financial records were audited every month. This showed that procedures were followed to help protect people from financial abuse.

We looked at four staff recruitment records to see if the home carried out adequate pre-employment checks. We found all pre-employment checks had been carried out including reference checks from previous employers and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults. This meant the home followed safe recruitment practices.

The manager told us the provider employed enough staff to keep people safe. We were told, and the staffing rotas showed that there was a team leader and three care staff employed during the day and two care staff, sometimes three employed at night. During the inspection we observed that this did not seem to be enough care staff to meet everyone's needs in a timely way. Staff were rushed in their jobs and therefore had little, if any time to stop and talk with people. We saw that basic care needs were met, but there was little time available for staff to engage in any meaningful conversations or activities with people. As well as providing personal care, administering medicines and serving food and drinks, care staff were all expected to do the laundry for everyone living at Aaron View. There was no-one employed specifically to undertake this task and we saw that it took staff away from their caring role.

A member of staff told us, "A lot [of people] require assistance to eat and drink and there are enough staff to meet perfunctory needs". Another member of staff told us that some people required two care staff to support them to have a bath, however, the current staffing levels made it difficult to regularly meet this need.

We asked people living at Aaron View if they could have a bath or shower whenever they wanted. One person told us, "When they [staff] have got time then you get a bath, but not every week." Another person said, "I had a shower every morning at home, now if they [staff] ask I will have a bath while I can."

We asked the manager how staffing levels were calculated and we were told that they recently undertook a night shift and monitored response times of staff when people pressed their call bells for assistance. The manager found the time taken to respond was acceptable and concluded the night time staffing levels were therefore acceptable. We asked if the provider used any staffing dependency tools to work out the level of care staff required to meet the care needs of each person. The manager wasn't aware of any tools being used.

The manager told us that a number of permanent staff had recently left the service and so the home was more reliant on agency staff than usual. We were told that recruitment was under way for replacements and they were hoping some of the regular bank staff would be given permanent hours. One person told us, "Staff's alright when they can get to you. There's lots of [staff] changes."

The lack of staff to meet people's needs in a timely way is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

Requires Improvement

Is the service effective?

Our findings

One person told us, "The food is alright. Never seen any fresh fruit out here." Another person said, "Can't grumble, lots of scampi and chicken casseroles, food's not bad at all." Another person told us, "I must admit I complained [about the lack of choice of food]. Sandwich choice was only cheese or cream cheese." This person went on to tell us they would like a bacon sandwich or a fry up for breakfast. We asked if this was an option and we were told, "You must be joking." We asked a member of staff about this and they said that occasionally people were offered a hot breakfast option of tomatoes or beans on toast. They thought some people would really like a cooked breakfast. We were told that sometimes bacon, egg and beans were served for lunch on Saturdays and this was popular. It was not an option for breakfast.

We saw the menu for the day was written on a whiteboard in the corridor downstairs. It listed the options available to people. There were no pictures to illustrate these options, which may have helped people who couldn't read what was on the board decide what they wanted to eat. There was no information displaying what the menus would be over the coming days. A member of staff told us, "The same meals were served week in and week out." They thought that people should be offered more choices at each meal time and there should be more variation of the different types of meals on offer. One person living at Aaron View told us, "It's regimental, you have to have dinner at 12 and breakfast at 8."

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centre care.

Some people needed support to eat their meals. We saw that appropriate equipment was provided to these people such as plate guards. Staff also supported people where required. Some people had special dietary needs such as requiring thickened food to prevent the risk of choking. We saw that staff were aware of people's nutritional needs and preferences.

We saw and staff told us they were provided with an induction to the job and ongoing training in order to carry out their jobs effectively. However, we were told that most of this training was self-directed. This meant staff were given a booklet to read around a particular subject, such as mental capacity and then had to complete a written test to check whether they had understood what they had read. This was then sent to an external company for marking. Classroom style training was given for practical issues, such a safe moving and handling techniques. Some of the staff we spoke to said they would like more training, particularly around medicines management and care for a person living with diabetes. The manager told us they had recently completed a 'training the trainer' course, which meant they would be able to deliver some training to staff themselves.

Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members. Appraisal is a process involving the review of a staff member's performance and improvement over a period of time, usually annually.
The manager told us that staff should receive supervision every two months. They acknowledged this hadn't happened consistently in recent months and they had now planned regular supervisions in the future for

most staff. We saw a copy of the staff supervision plan that the manager had nearly finished. We saw in staff files and were told that all staff had an appraisal last year and they were scheduled to take place again in April 2016.

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 to 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 are called the Deprivation of Liberty Safeguards (DoLS). There were locks in place at the top of communal doors at Aaron View. A person would need to know they were there and be able to physically reach up to open or close them. This meant people without capacity to decide where it was in their best interests to live, potentially had their movements restricted. The manager told us they were aware of their responsibilities under the MCA and had applied to the local authority for DoLS assessments for fourteen people living at Aaron View. We saw written evidence of this.

Some people we spoke with could recall having access to local healthcare professionals. While we were at Aaron View a District Nurse arrived to review four people's health needs. The manager told us they had a good relationship with the local GP practice, and a GP needed to be contacted during our inspection. The GP agreed to undertake an immediate visit to the home to see the person. The District Nurses' records were held separately and did not make up part of a person's care records. Information was shared verbally, however there was no evidence to suggest visits from health care professionals were regularly recorded on people's care records.

We saw that the reception area contained little information for people arriving at the home. The information that was displayed was not well presented. The home appeared clean, however the carpets and decoration looked tatty and worn out, and would have benefitted from freshening up.
The overall effect was unwelcoming.

Good

Is the service caring?

Our findings

One person told us, "Staff are all very nice. Another person told us, "Staff are lovely." A relative told us, "90% of staff are good." A member of staff told us, "The basic standard of care here is good for the staffing levels available." A visiting health professional told us, "Staff are really lovely, very helpful."

People looked to be happy with the care they received. We observed staff who were caring, listening to people and talking to them appropriately. Staff spoke to people respectfully, and bent or crouched down to talk to people who were sitting down so they could communicate at eye level.
We did hear one member of staff reprimand a person quite sharply when the person explained they had asked for mashed potatoes, but were served chips. The person was told, "you can have your dinner without chips." We brought this to the attention of the manager who was very surprised and disappointed to hear this.

We observed dinner being served. We saw staff rushing to take plates of food to people, but not saying anything to them and just placing the plate of food in front of the person and walking away to serve another person's meal. We heard a person asking for their food to be cut up. A member of staff responded to this request, but didn't speak to the person while cutting up their piece of fish. This could mean that people felt ignored while being served a meal.

Staff told us they knew people's likes and dislikes. We saw evidence of this as staff acknowledged people by name when they had any contact with them, and most staff knew which drinks and food choices people preferred. These staff offered encouragement and advice if a person was struggling to make a choice. However, one person told us they couldn't drink the cup of tea they had been given as it had sugar in it and they were diabetic.

Staff we spoke to were aware of how to treat people with dignity and respect and gave examples of how to do this. Staff told us of the need to provide personal care in the way a person wanted it and to use towels to cover people when delivering personal care to respect their privacy and maintain their dignity. We saw staff supporting people to their rooms so that a visiting health professional could see them in private. We saw staff knock on closed bedroom doors before they entered the room. We did not see or hear staff discussing any personal information openly or compromising privacy.

All staff we spoke to told us they would be happy for their loved ones to live at Aaron View, however some did also mention that they would like to see more activities and food choices available to people.

A member of staff was identified as a dignity champion at Aaron View. They were responsible for maintaining standards of dignity and respect throughout the home.

We asked the manager if any information regarding advocacy services was provided to people at the home. An advocate can speak up for someone who is unable to do this for themselves. The manager told us this information is not provided. There were no restrictions on visiting times at the home and the manager, and

some people who lived at Aaron View confirmed this to us.

Requires Improvement

Is the service responsive?

Our findings

We were shown around the home when we first arrived. We saw there was an activities board displayed in the corridor downstairs. There were no activities advertised on the board or anywhere else around the home. People living at Aaron View told us there weren't many activities on offer. One person said, 'There is some. I like to do puzzles. The [activities] room is only small, but I like it." Another person told us, "We don't do much [activities]. Bingo on Tuesday. I like to do word searches." One person told us, "I suppose [I like living here], I sleep most of the time."

We were told there was a part-time activities coordinator employed for 18 hours per week. However, some of this time was spent supporting people to have a bath and assisting with serving the tea time meal. A member of staff told us there was an exercise session in the main lounge every other Wednesday and that people really enjoyed these sessions. We were told the sessions were delivered by an external company and so were in addition to the hours provided by the activities coordinator. One staff member told us it was a shame these sessions couldn't happen more often as they were so popular. We spoke with the provider about the lack of activities available to people and we were told additional hours would be paid for.

We saw there was a lack of stimulation for people during the day. We saw people sitting in the same chairs in the downstairs lounge all day with nothing to do. The TV was switched on the entire time, but at times no-one was actually watching it.

Over half the people residing at Aaron View were living with dementia. We saw one person repeatedly shouting out the same word. Staff did briefly stop to ask what was wrong, but then carried on with what they had been doing. We looked at this person's care record and while it was recorded that this person did shout out, there was no plan as to how staff could manage this behaviour and reduce the distress the person was experiencing.

We saw that one person in particular liked to walk up and down the corridors. There were no sensory or tactile displays, no memorabilia or reminiscence photo montages. These would have provided simulation and interesting points of reference to their walk. There were no reminiscence areas, no sensory rooms, no rummage boxes and no resources for care staff to use to engage people living with dementia in meaningful activities.

There was a garden at the back of the home, however this could not be safely accessed by people living there. The manager told us there weren't any plans to rectify this. However, we were told that work was being undertaken to improve the patio area and create a sensory area outside.

Most of the care records we looked at were out of date and locked downstairs in the manager's office. We spoke with the manager and the provider about this and we were told that they were in the process of updating everyone's care records. We saw that eight had now been produced in the new format, which did give more detail and were up to date regarding a person's level of need.

We asked how a new member of staff would be able to care for people living at Aaron View as so much of the information held was out of date and locked away. For example, one care record we looked at stated that the person had capacity to make decisions and was dated 15 October 2013. This was no longer the case as the manager had recently applied for a DoLS for this person. Another care record gave no indication that the person was now being cared for in bed and required regular turning to prevent pressure sores. Neither of these care plans had been updated since June 2015.

The manager told us that staff could access their office in their absence to look at care plans. In addition we were shown that folders were held upstairs for people who required regular turning or close monitoring in some way. These were completed regularly by staff, but in no way reflected the information in their corresponding care records.

We saw that when reviews of people's care needs had taken place they were often recorded with very limited detail, such as 'no change,' and there was no evidence to suggest that the person or the person's family or friends had been consulted as part of the review. This was the case for both the new and out of date care records.

The lack of stimulation to promote good health and wellbeing and the out of date care plans with no evidence of people being involved in the reviews of their own care needs are breaches of regulation 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centre care and Good governance.

The manager told us that they were working to develop a keyworker system. This is where a person is allocated a specific carer to get to know them really well. Three people had been allocated a keyworker so far. One person told us, "I do [have a keyworker], I think. She sometimes asks me things but I don't who she is."

We saw there wasn't a complaints policy displayed anywhere and the manager confirmed this when we asked them. This would have given information to people living at Aaron View and their visitors about who to contact if they had a complaint and who to contact if they were unhappy with the initial response they received. The manager agreed this should have been displayed. The manager did show us a copy of the complaints procedure held in a file in one of the offices downstairs. This was only accessible to staff and was dated September 2010. The details of who to contact were no longer applicable.

The manager told us they had an 'open door' policy where people living at Aaron View, their visitors, and members of staff could approach them at any time to discuss any complaints or concerns they had. The manager had recently implemented a system in December 2015 to record any complaints made to them. We saw there had been six recently and the records did show whether the complaint had been upheld and what, if any action taken to resolve the issues. One of the six was made very recently and was currently being investigated.

Requires Improvement

Is the service well-led?

Our findings

We were told the registered manager left the service in January 2016. The deputy manager was covering this post until a new manager was recruited. The provider told us they had offered the job to an external candidate, however they had turned it down so the recruitment process was continuing. The deputy manager's post had not been backfilled at the time of our inspection, and the administrator who was employed for six hours a week had also left. We were told they were not going to be replaced and their tasks would become part of the deputy manager's role.

We saw, and we were told that the manager also continued to be part of the staffing rota, which meant undertaking several shifts a week alongside their management role without any administrative support. The registered provider did tell us a temporary consultant in care provision had just been employed for six weeks to support the temporary manager.

People told us that they were aware there wasn't a registered manager in post. One person said, "We haven't got a proper manager, they gave back word". Another person told us they knew that, "[Name] was a temporary manager, she's alright." Another person said, "We haven't got a manager. [Name] is covering and she does very well. Whatever you ask her she'll do it for you."

Following on from their 'enter and view' check, Healthwatch told us, "Generally we found the service was well liked by people and provided a good level of service, but the provider never responded to our requests for information, so the outcome of the visit remains a non-public document."

The manager told us there hadn't been a residents' meeting, or a meeting for relatives and friends for over a year. The manager told us, and we saw that the same questionnaire had been sent to residents, relatives and staff asking for their views of the services provided at Aaron View. Only three people had responded which meant that no detailed analysis of the results could be undertaken to pick up on any common themes, good or bad. The three that had been returned did highlight the lack of activities available to people, and problems with laundry going missing or returned to the wrong person. This meant, although people had been asked their opinions, these had not been listened to and acted on as people were still telling us improvements were needed with the activities provided.

We saw a record of a recent meeting on 3 February 2016 between the manager, and the team leaders and night staff. The meeting was recorded by the manager and they were in the process of typing up their handwritten notes. Staff told us the manager was approachable and you could "just ring her" if you needed to. Another member of staff told us, "[Name of manager] is sound."

There was a policy and procedures file covering all aspects of the service available to staff. We were told that staff were expected to read this as part of their induction. All of the policies and procedures were dated September 2010. This meant that they had not been updated for over five years to check they reflected any changes in current practice and legislation.

We saw that some audits were undertaken by the manager. The manager told us they walked around the home during each of their shifts to talk to people about any concerns they may have, and to check whether the premises were clean and safe. The manager did not have any formal written records of these checks being undertaken. This meant any problems identified were not logged so actions could be taken to resolve them, and then checked to see whether they had been resolved satisfactorily. The manager did show us their personal diary which contained brief notes of what they had found each day. There was a medication audit file, with the last audit recorded as being undertaken on 16 July 2015. The manager confirmed to us that this was an accurate record and they were aware they should have been done monthly.

We saw that infection control audits were undertaken every six months, the last one on 25 September 2015. The audit we saw showed that any issues were identified and acted upon. Staff told us they had enough equipment to do their jobs and had cleaning schedules to make sure all areas of the home were kept clean. We saw staff wearing gloves and aprons when appropriate. This showed that steps were taken to control infection.

We saw copies of water hygiene checks taking place each year. We also saw up to date copies of safety certificates for lifts and hoists, gas and fire.

The manager was aware of their obligations for submitting notifications in line with the Health and Social Care Act 2008. They confirmed that any notifications required to be forwarded to CQC had been submitted and evidence gathered prior to the inspection confirmed that a number of notifications had been received.

The lack of regular quality assurance check and audits, the out of date policies and procedures and no recent meetings with residents and their relatives to seek feedback is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There were not enough activities available to promote people's health and wellbeing, particularly those living with dementia. Service did not design care or treatment with a view to achieving service user's preferences (i.e. limited food options).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Care records were out of date and did not reflect the person's current level of need. No evidence the person or their relative had been involved in any reviews of their care, lack of regular quality assurance checks and audits, out of date policies and procedures not reviewed since September 2010, no meetings with residents and their relatives in the last 12 months to seek how to improve the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced

persons deployed.