Inspection Report on

Ashgrove House

ASHGROVE NURSING HOME
344-346
SWANSEA ROAD
SWANSEA
SA5 4SQ

Date Inspection Completed

25 September 2020
**About Ashgrove House**

| Type of care provided | Care Home Service  
|                       | Adults With Nursing |
| Registered Provider   | Ashgrove (Swansea) Ltd |
| Registered places     | 55 |
| Language of the service | English |
| Previous Care Inspectorate Wales inspection | 14 July 2020 |
| Does this service provide the Welsh Language active offer? | Working towards |

**Summary**

Ashgrove House needs to make urgent improvements so that people receive the best possible care in a safe, comfortable environment. Although people’s care and support needs are mostly being met, their health, safety and well-being are at risk. This is because people are exposed to environmental hazards and staff are not always available to supervise or assist them as needed. Staff are not receiving an induction relevant to their role and they are not up-to-date with their core training. This could impact on the quality of care and support they provide. People’s health is at risk because the service does not always manage people’s skin integrity appropriately and standards of hygiene and infection control are not satisfactory. This means that people may experience avoidable pressure damage or pick up an infection.

People get on well with care workers, but would benefit from more activity and interaction. Care workers know what matters to people and this is generally reflected in people’s personal plans. People are mostly happy with the food and drink available to them. People are able to make daily choices with regards to where and how they spend their time. Care workers do their best to make sure people are clean, comfortable and content.
Well-being

People have good relationships with care workers, who treat them in a dignified and respectful way. We found that people’s individual needs and preferences are generally set out within their personal plans. Care workers are able to speak confidently about what is important to people and we heard them supporting people to make everyday choices. We saw people enjoying light hearted conversations with care workers, although people would benefit from better, more consistent staffing levels. People told us they enjoy spending time with care workers, but they often have little to do and are kept waiting for assistance because staff are so busy. Activity charts show that the range of in-house activities people take part in is limited.

The service is not always provided in a way that keeps people safe. We found that low staffing levels and environmental hazards are compromising people’s safety. Chemicals and equipment are not being properly stored, which could lead to people being harmed. Feedback gathered during the inspection suggests that care workers are not always supervising people in communal areas, resulting in people not always receiving assistance when they need it. Records show that staff are not up-to-date with their core training, which could affect the quality and safety of the care and support they provide. People are at risk of experiencing pressure damage as they are not always being repositioned as regularly as needed and their pressure relieving mattresses are not always set as they should be. The service provider must take immediate action to address these issues.

People live in accommodation that is suited to their needs. People are satisfied with their individual bedrooms and can easily access bathroom facilities and outdoor areas if they wish. However, the service is not being provided in line with its statement of purpose: ‘Ashgrove aims to provide residents with a secure, relaxed and homely environment in which their care, well-being and comfort are of prime importance.’ We found that environmental hazards are putting people at risk of injury and ill health. The standard of cleanliness is also not satisfactory and some equipment, such as bedrail bumper pads, are in poor condition, making them more difficult to keep clean. This increases the risk of cross infection, which could impact on people’s health and well-being. This is of particular significance given the COVID-19 pandemic. The service provider must take immediate action to address this issue.
Care and Support

People told us they are happy living in Ashgrove House. One person said, “We are very lucky here.” We found that people’s individual needs and wishes are set out in risk assessments and personal plans that are generally well detailed and up-to-date. People with a high level of dependency appeared to be clean, comfortable and well-kempt. We saw that people had access to drinks in their individual bedrooms and in the communal lounge-diner. People generally complimented the food, although some commented that they would like more choice. We saw care workers supporting people with a baking activity. It was clear that people enjoy positive relationships with care workers. We heard care workers asking people what music they would like to listen to and saw them supporting people to access the outdoor courtyard safely.

The service does not always have enough staff to ensure people receive appropriate care and support. Worked staffing rotas show that there have been several occasions during September 2020 when shifts have not been adequately staffed. Staff told us they sometimes struggle to meet the demands of their workload. In the past month, relatives have reported that care is rushed, staff are not visible, people are not supervised in communal areas and there is little stimulation for people. Professionals told us they have observed the same issues during their time spent at the service. Activity charts show that people have taken part in a very limited range of in-house activities. The service has been operating without its full complement of domestic and maintenance staff, and we found issues relating to both the cleanliness and maintenance of the home.

In addition, staff do not always receive an induction and training appropriate to their role. The service does not have an up-to-date policy in place for the support and development of staff. There is no evidence that care workers have completed the relevant induction programme, as required by Social Care Wales. The staff training matrix shows that a number of staff are not up-to-date with their core training. This includes training in relation to health and safety, infection control, dementia care and safeguarding adults at risk. We have issued a priority action (non-compliance) notice to the service provider, who must take immediate action to address these staffing issues.

People are at increased risk of experiencing pressure damage. Records show that some people receive appropriate pressure relief, in line with their personal plans, whilst others do not. We saw from one person’s repositioning charts that there had been a number of occasions when they had not received the four hourly pressure relief they need. We also found that another person was using a pressure relieving mattress that had not been set correctly. This had occurred despite nursing staff carrying out airflow mattress checks twice a day. Professionals have told us they have previously raised these issues during their visits to the service. We have issued a priority action (non-compliance) notice to the service provider, who must take immediate action to address this.
Environment

People are at risk from hazards in their environment. We saw that storage rooms were not being kept locked, allowing people access to these cluttered areas where they may trip or fall. A cleaning trolley containing chemicals had been left unattended in one person’s bedroom with the door open. Failing to store cleaning products securely could result in people ingesting chemicals that would cause them physical harm. We saw that the carpet in one person’s bedroom was so badly damaged it posed a falls risk. Screws and nails had also been left sticking out of the walls in some rooms, which could have caused people injury. As a result, we have issued a priority action (non-compliance) notice to the service provider, who must take immediate action to address these issues.

People are at risk of cross infection because the service is not maintaining good standards of hygiene and infection control. We found some bathroom facilities to be in an unhygienic state, with faeces remaining on toilet seats for a number of hours. There was a lack of products, such as liquid hand soap, to support good hygiene. We saw that some people’s bedrail bumper pads are badly ripped and their carpets heavily worn and stained. Records show that many staff are not up-to-date with their infection control training. Professionals have recently observed staff not using personal protective equipment (PPE) appropriately. We have issued a priority action (non-compliance) notice and the provider must take immediate action to address these issues.
Leadership and Management

This inspection did not focus on the leadership and management of the service. However, relatives and professionals have told us that management do not always respond positively to feedback and sometimes provide conflicting information. The responsible individual is in regular contact with the home and needs to address the matters raised in this report as a matter of urgency. We noted that the service’s statement of purpose also needs more detail and policies and procedures need updating. These issues will be explored further at the next full inspection of the service.

Since the inspection, CIW has been informed that people are no longer able to access hazardous areas, the home has been thoroughly cleaned and general repairs have been carried out. People who need it have been provided with a pressure relieving mattress that automatically adjusts to their weight and nursing staff are continuing with twice daily mattress checks. Staff training in relation to infection control is also underway. These actions will be reviewed at a follow up inspection.
Areas for improvement and action at the previous inspection

<table>
<thead>
<tr>
<th>The service does not always promote hygienic practices.</th>
<th>Regulation 56(1)(a)</th>
<th>Not Achieved</th>
</tr>
</thead>
</table>
| People are not always supported by appropriately trained staff. The skill mix of staff is not always adequate. | Regulation 36(2)(d)  
Regulation 34(1)  
Regulation 34(1)(a)  
Regulation 34(1)(b)  
Regulation 34(1)(c)  
Regulation 34(1)(d) | Not Achieved |

Where providers fail to improve and take action we may escalate the matter by issuing a priority action (non-compliance) notice.

Areas where immediate action is required

<table>
<thead>
<tr>
<th>The service needs to manage people’s skin integrity more effectively to ensure that risks to people’s health and well-being are minimised. The service provider must ensure that care and support is provided in a way which protects, promotes and maintains the safety and well-being of residents.</th>
<th>Regulation 21(1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>People are being exposed to hazards in their environment. The service provider must ensure that any risks to the health and safety of residents are identified and reduced so far as is reasonably practicable.</td>
<td>Regulation 57</td>
</tr>
<tr>
<td>Satisfactory standards of hygiene and infection control are not being maintained. The service provider must have arrangements in place to ensure satisfactory standards of hygiene and infection control in the delivery of the service.</td>
<td>Regulation 56(1)(a)</td>
</tr>
</tbody>
</table>
| There is not always a sufficient number of suitably trained staff to work at the service. Staff do not always receive an induction and training appropriate to their role. The service provider must ensure that at all times a sufficient number of suitably qualified, trained, skilled, competent and experienced staff are deployed to work at the service. The service provider must have a policy in place for the support and development of staff. | Regulation 34(1)  
Regulation 34(1)(a)  
Regulation 34(1)(b)  
Regulation 34(1)(c)  
Regulation 34(1)(d)  
Regulation 36(1)  
Regulation 36(2)  
Regulation 36(2)(a) |
We found poor outcomes for people, and a risk to people’s wellbeing, which is likely to continue if no action is taken. Therefore, we have issued priority action (non-compliance) notices and expect the provider to take immediate steps to address these and make improvements.

Areas where improvement is required

Date Published: 25 March 2021
Care Inspectorate Wales

Regulation and Inspection of Social Care (Wales) Act 2016

Non Compliance Notice

Care Home Service

This notice sets out where your service is not compliant with the regulations. You, as the registered person, are required to take action to ensure compliance is achieved in the timescales specified.

The issuing of this notice is a serious matter. Failure to achieve compliance will result in Care Inspectorate Wales taking action in line with its enforcement policy.

Further advice and information is available on our website www.careinspectorate.wales

Ashgrove House

ASHGROVE NURSING HOME
344-346
SWANSEA ROAD
SWANSEA
SA5 4SQ

Date of publication: 25 March 2021
Non-compliance identified at this inspection

Timescale for completion | 20/11/20

<table>
<thead>
<tr>
<th>Description of non-compliance/Action to be taken</th>
<th>Regulation number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents are being exposed to hazards in their environment. The service provider must ensure that any risks to the health and safety of residents are identified and reduced so far as is reasonably practicable.</td>
<td>57</td>
</tr>
</tbody>
</table>

Evidence

The service is not compliant with Regulation 57 of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017.

This is because the service provider has failed to ensure that any risks to the health and safety of individuals are identified and reduced so far as reasonably practicable.

The evidence observed is as follows:

The Local Health Board and Local Authority carried out a joint monitoring visit to the service on 23 September 2020. Officers observed several environmental hazards:
- There were exposed wires from an electrical socket in one resident’s bedroom.
- One resident could not reach their call bell and needed to shout to get staff’s attention.
- A member of staff was staying in the home but their room did not have a lock. Medication had been left on the bed in this room.
- One bathroom did not have a call bell. There was also exposed pipework, missing wall tiles, a broken radiator knob and missing shower head. There was evidence that residents had used this room.

Other observations officers made are referenced below.

CIW observed the following during an inspection that began on 25 September 2020:

1) Residents had access to rooms containing various hazards:
   - Room 5 was almost entirely full of equipment, such as wheelchairs, walking frames and armchairs. The door opened directly onto a wheelchair that was partially obstructing the doorway. This placed anybody entering this room at increased risk of trips and falls. This room was also found to be unlocked during a joint monitoring visit by the Local Health Board and Local Authority on 23 September 2020. Officers had requested that this room be locked, but this had not been actioned by the day of the inspection.
   - Bathroom 201 did not have a functioning toilet. Pipes were hanging above the toilet bowl where the cistern would be. A cistern lid was placed on a shelf next to the toilet. A paintbrush had been left on a small table under the sink. These issues placed anybody
entering this room at increased risk of injury.

- A cleaning trolley had been left unattended in a resident’s bedroom. The door to this bedroom was open. There were various chemicals on this trolley, including spray polish, glass cleaner and a large tub of cleaning fluid. Failing to store harmful substances securely can result in people ingesting chemicals that would cause them physical harm.
- A storage room door had not been closed properly despite being fitted with a keypad. This room contained numerous boxes of personal protective equipment. There was no shelving in this room so the boxes were on the floor with other items stacked on top of them. There was little floor space left in this room. This placed anybody entering this room at increased risk of trips and falls.

2) We found the following hazards within resident bedrooms:

- The carpet in room 43 was in very poor condition. The floorboards were visible through holes in the carpet in the main doorway and doorway leading to the en suite bathroom. The carpeting next to the bed was also scuffed and frayed. This created an uneven, unsafe floor surface.
- The radiator cover in room 35 was wobbling as it was not fixed securely to the wall. This had the potential to cause injury to the individual occupying this room.
- Numerous screws and nails had been left in the wall alongside the bed in room 55. These had the potential to injure the individual occupying this room. Officers from the Local Health Board and Local Authority had requested that these be removed during their joint monitoring visit on 23 September 2020. This had not been actioned by the day of the inspection.

3) We found the following hazards within communal bathrooms:

- A toilet roll holder appeared to have fallen off the wall in bathroom 203. This was a small bathroom with minimal floor space. A screw was protruding approximately 1.5 inches from the wall where the toilet roll holder had been. There was exposed pipework in this room. These issues had the potential to injure any individual using this bathroom.
- There was no call bell in shower room 101 and two screws had been left in the back of the door. This had the potential to injure those using the room and prevented people from summoning help or assistance should they need it.

The evidence shows:
- People are at increased risk of falls as equipment is not being safely stored, furniture is not always securely fixed and floor surfaces are uneven in places.
- People are at increased risk of ingesting harmful chemicals as these are not always being stored securely.
- People are at increased risk of sustaining burns on exposed pipework and injuring themselves on screws and nails that are protruding from walls and doors.
- People are unable to summon assistance in a shower room should they need it as there is no call bell facility.

The impact for people using the service is that they are at increased risk of injury and ill health due to hazards in their environment. People may not feel valued or respected living in an environment that places them at risk of harm.
Non-compliance identified at this inspection

<table>
<thead>
<tr>
<th>Description of non-compliance/Action to be taken</th>
<th>Regulation number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin integrity needs to be managed more effectively to ensure that risks to the health and well-being of residents are minimised. The service provider must ensure that care and support is provided in a way which protects, promotes and maintains the safety and well-being of residents.</td>
<td>21(1)</td>
</tr>
</tbody>
</table>

**Evidence**

The service is not compliant with Regulation 21(1) of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017.

This is because the service provider has failed to ensure that people’s skin integrity is managed appropriately.

The evidence observed is as follows:

1) A nurse assessor from the Local Health Board visited the service on 8 September 2020 as a result of a safeguarding concern. During this visit, the nurse assessor identified concerns relating to the management of people’s skin integrity:
   - One resident was found to have a red, non-blanching sacrum and their foot was pressing against their mattress. The pressure-relieving mattress had not been set to the correct weight for the resident, so the correct pressure relief was not being provided. This resident required 2-4 hourly repositioning but their repositioning chart showed occasional gaps in repositioning of 6 hours.
   - One resident was found to have a red, swollen, inflamed toe that staff were unaware of.
   - The alarm was sounding on one airflow mattress, which was in use and needed to be replaced.

2) A nurse assessor from the Local Health Board visited the service on 23 September 2020 and viewed records relating to the repositioning of residents. The nurse assessor found that three residents had not been repositioned as often as they needed, as stated in their personal plans. The nurse assessor also found that another individual's pressure-relieving mattress had not been set to the correct weight, so the correct pressure relief was not being provided.

3) CIW observed the following during an inspection that began on 25 September 2020:
   - One individual’s personal plan identified that they required an airflow mattress to promote their skin integrity. A risk assessment confirmed they were at very high risk of developing pressure ulcers. The personal plan stated that the pressure of the mattress needed to be
checked daily to make sure it was set according to the individual’s weight. We found that the mattress had not been set to the correct weight, so the correct pressure relief was not being provided.

- Another individual’s personal plan did not correctly identify the type of pressure relieving mattress they were using and how this should be checked. A risk assessment confirmed they were at very high risk of developing pressure ulcers. The personal plan stated that this individual needed to be repositioned every four hours to promote their skin integrity. We looked at the repositioning charts for this individual from 19 September 2020 to 25 September 2020 and saw that there were eight occasions when this individual’s position had not been changed for over four hours. On one occasion, this individual’s position had not been changed for over twelve hours.

- The system for checking people’s pressure-relieving mattresses was not effective. Some individuals had an automatic pressure-relieving mattress and others had a mattress with a pump that needed to be manually set according to the individual’s weight. We saw that the type of mattress an individual was using had not been stated on the form used to record the airflow mattress pressure checks. Where applicable, the individual’s weight had also not been recorded. Although twice daily mattress checks had been documented, these had not prevented an individual from continuing to be cared for on a mattress that was not correctly set to their weight. This meant that the correct pressure relief was not being provided.

The evidence shows that people’s skin integrity is not being managed appropriately. Care documentation is inconsistent so the type of pressure relieving mattress an individual needs and how this should be checked is not always clear. People are not always being repositioned as often as needed to promote good skin integrity.

The impact for people using the service is that they are at increased risk of experiencing pressure damage. This could have a significant impact on their overall health, comfort and well-being.
Non-compliance identified at this inspection

<table>
<thead>
<tr>
<th>Timescale for completion</th>
<th>20/11/20</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Description of non-compliance/Action to be taken</th>
<th>Regulation number</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is not always a sufficient number of suitably trained staff to work at the service. Staff do not always receive an induction and training appropriate to their role. The service provider must ensure that at all times a sufficient number of suitably qualified, trained, skilled, competent and experienced staff are deployed to work at the service. The service provider must have a policy in place for the support and development of staff.</td>
<td>34(1)(a) 34(1)(b) 34(1)(c) 34(1)(d) 36(1) 36(2) 36(2)(a) 36(2)(d)</td>
</tr>
</tbody>
</table>

**Evidence**

The service is not compliant with Regulations 34(1)(a)(b)(c)(d) and Regulations 36(1)(2)(a)(d) of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017.

This is because there is not always a sufficient number of suitably trained staff to work at the service, and staff do not always receive an induction and training appropriate to their role.

The evidence observed is as follows:

- CIW carried out an inspection on 14 July 2020 and advised the responsible individual that legal requirements were not being fully met as staff had not received core training relevant to their work and the number and skill mix of staff on duty was not always appropriate. This was because a staff dependency tool was used to help determine appropriate staffing levels, but rotas showed that this was not consistently followed. Some care workers had not completed training in moving and handling and infection control, and often worked together during times when there were fewer staff on duty. A notice of non-compliance was not issued on this occasion. This was because there was no immediate or significant impact for people using the service and CIW were satisfied with the proposed actions to address the issues raised. These included reviewing the staffing rotas to ensure an appropriate skill mix of staff for each shift, and reviewing overall staffing levels with the use of a staff dependency tool.

- A nurse assessor from the Local Health Board visited the service on 8 September 2020 as a result of a safeguarding concern. During this visit, staffing issues were identified:
  - Residents had been left unsupervised in the communal lounge and dining area. They were asking for drinks and for assistance with toileting.
  - One resident was tearful and feeling lonely and isolated.
  - One resident was observed sleeping at 10.48am with their breakfast left untouched on
The bedside table beside them.
- The nurse assessor assisted one resident with toileting as they had used their call bell some time ago to summon staff, but staff had not been to attend to them.
- Four residents needed assistance with personal hygiene, such as continence care and nail care.

- The Local Health Board and Local Authority carried out a joint monitoring visit to the service on 23 September 2020. Officers found a lack of staff presence on the first floor, where residents did not always receive the assistance they needed or wanted at mealtimes. One resident reported not seeing staff throughout the day. Three relatives have also reported concerns regarding staffing levels over the last month. These relate to staff not providing adequate supervision of communal areas and a lack of activities and stimulation. This feedback suggests that the number and deployment of staff is not always appropriate to meet the needs of residents.

- CIW observed the following during an inspection that began on 25 September 2020:

Staffing levels
- The service uses a dependency tool to help determine how many staff are needed each shift to meet people’s care and support needs. This dependency tool had been reviewed on 23 September 2020, but we found that one person had not been included in the calculation. Once their dependency level had been accounted for, the numbers of staff needed during shifts increased. This meant that the system for determining appropriate staffing levels had not been reliable. We also noted that the service’s statement of purpose gives no indication as to how staff are deployed to work at the home.
- The staff dependency tool indicated that 6 care staff were needed from 7am-1pm, 5 care staff were needed from 1pm-7pm and 3 care staff were needed overnight from 7pm-7am. This is in addition to a qualified nurse. The rota shows that:
  - Only 4 care staff worked during the afternoons of 19 September 2020 and 26 September 2020.
  - Only 5 care staff worked the morning shift of 15 September 2020 and only 4 worked that afternoon.
  - Only 2 care staff worked the night shift on 18 September 2020.
- We found that worked staffing rotas were not always clear and accurate. This is because the full names of staff had not been recorded for some permanent staff and some agency workers. Worked rotas indicated that there had not been a nurse on duty during the day on 13 September 2020 and 14 September 2020. However, the manager confirmed that an agency nurse had covered these shifts, but this had not been recorded on the rota.
- The home employs three Registered Nurses, including the clinical lead. Staffing rotas show that the clinical lead regularly works 60 hours a week. The clinical lead told us they did not always have time to complete their management tasks due to being the only full time nurse working day shifts. Due to the COVID-19 pandemic, accessing GP services also took longer, which impacted on the clinical lead’s workload. We identified issues in relation to the management of people’s skin integrity. This has resulted in the issuing of a separate non-compliance notice.
- One resident told us staff had little time to speak with them and they often had to wait for a response to their call bell because staff were busy. Another resident told us many people napped in the lounge as there was not much to do. A staff member told us that activities within the home had recently reduced, as care staff did not have the time to carry these out in addition to their caring duties. Activity charts showed that there had been little variety in
the provision of activities from 29 August 2020 to 25 September 2020.

- The service had been operating without its full complement of domestic and maintenance staff. We found evidence of poor standards of hygiene and maintenance of the home. The issues identified are set out in separate non-compliance notices.

Staff training
- The service does not have an up-to-date policy for the support and development of staff. The manager reviewed a ‘Staff Training and Qualifications (Wales) Policy’ shortly following the inspection, on 28 September 2020. However, this policy was underpinned by legislation that is no longer relevant.
- Induction checklists are completed for new staff, although we found these to be very basic. There was no evidence that care workers had been supported to complete the All Wales Induction Framework for Health and Social Care (AWIF), as is required.
- The home’s statement of purpose specifies that all staff are required to complete in-house training in the following subjects during their induction:
  o Fire and emergency systems
  o Confidentiality
  o Infection control
  o Care tasks
  o Care workers’ responsibilities
  o Care code and conduct
  o Health and safety
  o The rights of residents
  o Residents’ documentation

There was no clear evidence that this training had been provided. This is because some of these training topics are not covered in the home’s induction checklist or staff training matrix. There are also shortfalls in training, as set out below.
- We viewed the current staff training matrix and saw that staff had not completed various training within the set timescales. These included the following:
  o 13 out of 40 staff have completed dementia training in the last three years.
  o 15 out of 40 staff have completed Control of Substances Hazardous to Health (COSHH) training in the last year.
  o 17 out of 40 staff have completed health and safety training in the last three years.
  o 18 out of 40 staff have completed infection control training in the last two years.
  o In the last three years, 13 out of 30 staff have completed training in relation to safeguarding adults at risk. There is no indication that the ten kitchen, housekeeping and maintenance staff have completed, or are required to complete, training in this topic.

The evidence shows:
- The systems in place for determining and recording the number of staff working at the home are not reliable.
- There have been occasions when shifts have not been adequately staffed.
- The service does not have an appropriate policy in place for the support and development of staff.
- Staff are not up-to-date with their core training.

The impact for people using the service is as follows:
- People may not experience appropriate, responsive care, which puts their physical health and overall well-being at risk.
- Failing to adequately supervise people compromises their safety and could result in them...
- People’s emotional and mental health is being compromised by a lack of stimulation.
- People may be at increased risk of harm when supported by staff who have not received adequate training.
Environment

Our Ref: NONCO-00009646-DTSP

Non-compliance identified at this inspection

Timescale for completion

20/11/20

Description of non-compliance/Action to be taken

<table>
<thead>
<tr>
<th>Satisfactory standards of hygiene and infection control are not being maintained. The service provider must have arrangements in place to ensure satisfactory standards of hygiene and infection control in the delivery of the service.</th>
<th>Regulation number</th>
</tr>
</thead>
<tbody>
<tr>
<td>56(1)(a)</td>
<td></td>
</tr>
</tbody>
</table>

Evidence

The service is not compliant with Regulation 56(1)(a) of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017.

This is because the service provider has failed to ensure satisfactory standards of hygiene and infection control in the delivery of the service.

The evidence observed is as follows:

- The Local Authority and Local Health Board carried out a joint monitoring visit to the service on 23 September 2020. Officers observed that staff did not always wear their personal protective equipment (PPE) appropriately. This had also been identified by CIW at a previous inspection carried out on 14 July 2020.

CIW began an inspection on 25 September 2020 and observed the following:

- We found poor standards of hygiene in communal bathrooms and resident bedrooms:
  1) At around 10.30am, faeces was observed on the toilet seat and bowl in bathroom 104. This toilet had still not been cleaned by 2.30pm.
  2) A commode in room 18 appeared to have been emptied but the bowl was heavily marked with brown stains.
  3) The toilet in bathroom 201 had no flush mechanism, yet there was some toilet paper down the toilet and the toilet water was dirty.
  4) There were dirty marks on the curtains in room 35 and there were crumbs and stains on the carpet.
  5) The carpet in room 43 was heavily worn and stained. There were crumbs and rubbish on the floor under the bedside table.
  6) There was a large dirty splash mark on the wall by the bed in room 55. There was ingrained dirt along the skirting boards.
  7) The toilet and sink needed cleaning in one of the ground floor shower rooms.
  8) There was faeces on the toilet seat and bowl in bathroom 203. There were also dirty drip stains down the wall.
Some equipment and furnishings were in poor condition, making them more difficult to keep clean. This increases the risk of cross contamination:

1) The edge of the bath panel in bathroom 106 was ripped in four places.
2) The toilet roll holder had come off the wall in bathroom 203 and was resting on the sanitary bin. The plaster was peeling in one corner of this small room.
3) The bedrail bumper pads in room 58 were badly ripped.
4) The bedrail bumper pads were ripped in room 18 and the wooden bedframe was very scratched.

Some bathroom facilities lacked appropriate infection control measures:

1) There was no bin liner in the bin and no toilet roll holder in bathroom 202.
2) There was no toilet roll holder in bathroom 106.
3) There was no liquid hand soap in bathroom 205.
4) There was no liquid hand soap in bathroom 206 and used handtowels had been thrown on top of the bin lid.
5) There was an open top rather than lidded bin in bathroom 201.
6) A bar of soap had been left on the sink in shower room 101. This increases the risk of cross infection if used by multiple people.

Many staff have not received infection control training in the last 2-3 years. This was identified at the previous inspection carried out in July 2020 and we saw little evidence that this has been addressed. The staff training matrix indicates that:

- 1 out of 3 nurses have completed infection control training in the last two years.
- 10 out of 26 care staff have completed infection control training in the last two years.
- 6 out of 10 domestic, maintenance and catering staff have completed infection control training in the last three years.

The evidence shows that:

- People are living in an unhygienic environment that increases their risk of cross infection.
- The equipment and products needed to support good hygiene are not always available.
- Staff have not had adequate formal training to assist them in maintaining satisfactory standards of hygiene and infection control.

The impact for people using the service is that they are at increased risk of cross infection that may cause them ill health. This is of particular significance given the current COVID-19 pandemic.

People may not feel valued or respected living in an unhygienic environment.