Cieves Limited

Gorselands Residential Home

Inspection report

25 Sandringham Road
Hunstanton
Norfolk
PE36 5DP

Tel: 01485532580

Date of inspection visit:
22 February 2017
23 February 2017

Date of publication:
20 June 2017

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

This inspection took place on 22 and 23 February 2017 and was unannounced. Gorselands Residential Home is a care home providing personal care for up to 21 people, some of whom live with dementia. On the day of our visit 18 people were living at the home.

The last registered manager left the position in November 2014, although their registration with us was not cancelled until February 2016. 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 was a manager in post during this visit who was in the process of applying for registration with us.

At the last inspection on 12 July 2016, we asked the provider to take action to make improvements to assessing risks to people, staffing levels, medicine management, mental capacity assessments, care planning and activities, and monitoring the quality of the service. Some of this action, such as completing individual risk assessments, mental capacity assessments, staffing levels, and the availability of activities and social stimulation for people had been improved. Other areas, such as care planning records had been reviewed and improvements were on-going. There had not been enough improvement in two areas.

People did not always receive their medicines when they needed them, and medicine administration records did not always show why medicines had not been given.

The quality of the service was not effectively monitored for the risks to people, to ensure that these were reduced as much as possible and to improve the quality of the care provided.

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

Staff were aware of safeguarding people from the risk of abuse and they knew how to report concerns to the relevant agencies. They assessed individual risks to people and took action to reduce or remove them.

There were not always enough servicing and maintenance checks to fire equipment and systems in the home to ensure people's safety.

People felt safe living at the home and staff supported them in a way that they preferred. There were enough staff available to meet people's needs and the manager took action to obtain additional staff when there were sudden shortages. Recruitment checks for new staff members had been made before new staff members started work to make sure they were safe to work within care.

Staff members had received training, to provide them with the skills and knowledge to carry out their roles, although this training was not always refreshed or up to date. Staff received adequate support from the

manager and the provider's representative, which they found helpful.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The manager had acted on the requirements of the safeguards to ensure that people were protected. Where someone lacked capacity to make their own decisions, the staff were making these for them in their best interests.

People enjoyed their meals and were able to choose what they ate and drank. They received enough food and drink to meet their needs. Staff members contacted health professionals to make sure people received advice and treatment quickly if needed.

Staff were caring, kind, respectful and courteous. Staff members knew people well, what they liked and how they wanted to be treated. They responded to people's needs well and support was always available. Care plans contained enough information to support individual people with their needs. People were happy living at the home and staff supported them to be as independent as possible.

A complaints procedure was available and people knew how to and who to go to, to make a complaint. The registered manager was supportive and approachable, and people or other staff members could speak with them at any time.

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.

Staff assessed individual risks and acted to protect people from harm. People felt safe and staff knew what actions to take if they had concerns about people's safety.

Fire safety equipment, staff knowledge and checks were not always available, up to date or completed to keep people safe.

There were enough staff available to meet people's care needs. Checks for new staff members were obtained before they started work to ensure they were appropriate to work within care.

Medicines were not always administered to people when they needed them.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had received up to date or refresher training to provide people with the care they required.

Mental capacity assessments and best interests decisions had been completed for decisions that people could not make for themselves.

Staff contacted health care professionals to ensure people's health care needs were met.

People were given a choice about what they ate and drinks were readily available to maintain people's hydration.

Is the service caring?

Good

The service was caring.

Staff members developed good relationships with people living at the home, which ensured people received the care they wanted in the way they preferred.

Staff treated people with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not have all of their individual care needs planned for and staff were knowledgeable about the care people required to meet all aspects of their needs.

Staff provided enough activities and events for people to ensure they were stimulated and did not become isolated.

People had information if they wished to complain and there were procedures to investigate and respond to these.

Is the service well-led?

Requires Improvement

The service was not well led.

Staff members worked well with each other, people's relatives and people living at the home to ensure they received a service they wanted.

Good leadership was not in place and the quality and safety of the care provided was not regularly monitored to drive improvement. Identified issues continued without adequate action to improve or prevent other issues occurring.

Gorselands Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 22 and 23 February 2017 and was unannounced. This inspection was undertaken by two inspectors.

Before the inspection we reviewed information available to us about the service, such as the notifications they should sent us. A notification is information about important events, which the provider is required to send us by law.

We spoke with three people using the service and with two visitors. We also spoke with the manager, the provider's representative and four care staff during our visit.

We spent time observing the interaction between staff and people living at the home. We looked at the care records for four people, and we also looked at the medicine management process. We reviewed the records maintained by the home in relation to staff training and how the provider monitored the safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in July 2016 we identified two breaches of Regulation 12 and a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to the assessment of risks to people, including those in regard to the evacuation of people in an emergency, the safe management of medicines and staffing levels. Following our inspection the provider did not tell us what action they intended to take to address the breaches in regard to the evacuation of people or the management of medicines. They told us that they had removed one person's bed rail, which we had identified as a risk to the person, and that there were adequate staffing levels.

During this visit we found that systems were not robust in ensuring that people always had access to the medicines prescribed for them and that medicines records were accurate. We identified concerns that one person had not received two of the medicines prescribed for them as there were no signatures for these medicines on one day. In addition, inaccuracies in records indicated that the person may have been without these medicines for longer than one day. This was because there were differences in the number of these medicines received into the home and the number staff signed for as given, which was more than the number received. At the time of our visit neither of the two medicines was available within the home for staff to administer.

For each of these two medicines, 18 doses of the medicines were signed for as given. The record of the amount of each medicine received showed this was not possible. For example, the medicine administration record (MAR) showed ten tablets of Folic acid were received but 18 doses had been given. The same person's medicine used to treat heart failure, was not available for them in the home. Their record for the prescribed dose of Digoxin on the day of our inspection was blank. The MAR chart showed that staff received 15 of these tablets, but again there were 18 signatures for administration and one blank. This suggested that either the balances were wrong, or that this person may have been without the essential medicine for up to four days. This presented concerns for the person's health and welfare.

The provider's representative was not able to find anything in the person's daily notes to show what had been done to ensure the medicines were obtained. They agreed that the checking and auditing process was not robust in identifying there was a problem and following it up promptly. They contacted both the person's GP and the pharmacy to try and resolve this.

We found that some people required insulin for the treatment of diabetes and one of these people needed staff to administer the insulin. Staff explained that two other people required staff to check that the person themselves was administering the required dose safely. Normal practice was for the staff member supervising, to sign the MAR chart to say they had done this. We found there were omissions of signatures on two days for the administration of insulin to one person and for the supervision of two people who gave their own insulin.

Four other people's MAR charts showed gaps in recording that medicines had been given, with no accompanying explanation for the medicine not to have been given. For one person the medicine was

missing from the blister pack, which indicated that it had probably been given to the person. Another person may have received their medicine, although we could not be sure as the medicine was not in a form that could be counted. However, for the other two people medicines were still available and they had not received these as prescribed.

We noted that tubs of antiseptic cream in use in two people's rooms were not dated when they were opened. Creams and lotions are at risk of contamination once they are opened. Those in tubs are particularly at risk as their contents are exposed once they are opened. Good practice is that these should be disposed of a month after opening to ensure they remain safe and effective to use. The lack of dates meant that staff were not able to monitor this.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that staff ensured they offered one person some of their medicines before their meals. This was consistent with guidance about managing the medicines in a way that minimised the risk of side effects and promoted the effectiveness of the medicine itself. Staff explained to the person what the medicines were, why they needed to take them, and ensured they had a drink available to help them swallow the medicines. For other people, we saw that staff offered pain relief where this was needed. One person complained about having a headache and staff responded quickly to offer them pain relief, which they accepted.

We found that there had been an improvement in how staff assessed risks to people who used bed rails, their individual risks around pressure ulcer development and the availability of personal emergency evacuation plans. Staff members assessed risks to people's safety and documented these in each person's care records. These were individual to each person and described how to minimise any risks they faced during their daily routines. These included any risks with their mobility, the risk of falling and reducing the likelihood of any damage to their skin, which could develop into a pressure ulcer. Personal emergency evacuation plans (PEEPs) were available to guide staff or emergency services what support people required in the event of an emergency, such as a fire. We concluded that individual risks had been appropriately assessed and reduced as much as possible.

The equipment people used had been maintained and serviced. However, we noted that the most recent certificates available for hoist servicing and legionella testing were over a year old. We also found other concerns with how the provider made sure fire safety risks were reduced and the safety of people in the event of a fire. Risks associated with the safety of the premises in the event of fire were not well managed.

We spoke with two staff in depth about fire safety. Neither staff member felt that they had received adequate fire safety training. When we spoke with both staff members, they were not clear about the actions they should take in the event of a fire or how to evacuate people who were unable to walk. We noted through talking with staff that there was no evacuation equipment such as chairs, mats or mattresses for this process. The provider's representative told us that they had obtained this equipment, although it was not available in the home for staff to use.

We found that some fire safety checks had not been properly completed since November 2015 but that when they had, they identified issues that remained at the time of our visit. Not all fire doors could be guaranteed to resist a fire for 30 minutes. Other concerns, such as the storage of different types of extinguisher in the same area had also been identified as not meeting the British Standard. Holes in the ceiling and in an electrical cupboard had not been repaired to prevent smoke and flames entering ceiling space.

The provider's representative explained that they were aware there were nine fire doors that they needed to replace, following an inspection by the fire service in October 2016. The fire service had issued a 'notification of deficiencies notice' requiring the provider to comply with their requirements by 26 May 2017. We found that environmental risks had not always been appropriately assessed and reduced as much as possible.

People told us that they felt safe living at the home and they were complimentary about the way staff members treated them. One person told us, "Everyone is very nice. I have no concerns." A visitor to the home said, "We haven't seen or heard anything that concerns us."

We saw that people interacted cheerfully with staff and showed no reluctance to ask for assistance when they needed it. The provider had taken appropriate steps to reduce the risk of people experiencing abuse. Staff members demonstrated an understanding of the different types of abuse and provided explanations of the actions they would take if they thought abuse had occurred. They knew where to find information on how to report any concerns to the local authority, who lead on any safeguarding concerns, if they needed to report an incident of concern. Staff confirmed that they had received training in safeguarding people and records we saw confirmed this.

People told us that they thought there were enough staff available. One person told us, "They come quickly when I use the bell. I'm not kept waiting." Another person said, "They can always find time to talk to me."

Staff members told us generally that there were enough staff available on each shift. However, they also said that if there was a sudden shortage of staff, such as for sick leave, this sometimes caused problems. They told us that an additional staff member was employed at tea time to help during this busy period and that this had helped things. One staff member also told us that the manager and deputy manager had started an on call system where staff could call on them if required. The staff member said that they had done this on a couple of occasions and it had worked well.

We observed that staff responded to call bells promptly. While we were present on the first floor, a member of staff responded to one person's call bell in less than a minute. Another person told us that they were feeling cold. We raised this with a staff member who checked immediately whether the person would like them to fetch their cardigan and assisted the person with this very quickly. The staff rota showed that staffing numbers were at the level deemed appropriate by the provider's representative and the deputy manager had completed a summary of how long they took to provide each person with care. However, this was a subjective approach to each person's care needs and did not provide a clear structure to show why people required differing amounts of time.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in July 2016 we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because mental capacity assessments and best interest decisions had not been completed for those people who may have lacked capacity to make decisions. Staff had completed assessments for other people who had capacity to make decisions, which did not recognise the principles of the Mental Capacity Act 2005 (MCA). Following our inspection the provider told us that they had completed a mental capacity assessment for the person who was not able to make decisions about their care.

The 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 checked whether the service was working within the principles of the MCA. We found that staff completed mental capacity assessments where they had concerns that people may not be able to make their own decisions. These were only for decisions where staff had concerns and they recognised that they should support people to continue making their own decisions for as long as possible. We saw that staff had information about how to help one person with fluctuating capacity. Staff also had written guidance about how to help people to do this for their everyday lives and routine activities, such as which clothes to wear and how to choose what to eat at mealtimes.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). These require providers to submit applications to a 'supervisory body' for authority to lawfully deprive a person of their liberty. The manager had submitted applications to the local authority for people living at the home.

People told us that staff asked for their permission before helping them with anything. They told us, "They check if it's alright with me." Another person agreed that staff asked them what they needed and whether they wanted help.

We observed that staff consistently asked people's permission before attending to their needs. For example, at lunchtime a staff member asked if they could put an apron on someone. For other people, they asked if they would like assistance to eat their meal. One person discussed with staff a problem they were having with dentures. The staff member checked with them whether they would like help and secured their agreement before taking them to assist. This gave people the opportunity to agree or decline the help and to give their consent to the care that was offered.

People's care needs were not always met by staff members who had been suitably trained and had the knowledge and skills required.

One staff member told us that they had not received any training since working at the home. Other staff told us that they had received some training at this home and some training at other care services that they had worked at. A staff member who had received training elsewhere confirmed that they had not been asked to show what this was or when they had received the training.

We saw that some staff had received training in 2016 but that other staff had last received updated training in 2015. Three staff members had no training certificates at all and there was no record to show that they had attended any training sessions. The provider's representative and manager were unable to locate any other training records during our visit. We were therefore unable to determine whether staff kept up to date with training, to provide them with up to date knowledge and opportunities to develop their skills.

The provider's representative told us that they had not had a manager in post for quite some time and this had resulted in the lack of organisation. They also told us about the actions they and the manager had taken, such as arranging for staff to attend training sessions at another care home and planning additional training sessions with a training company. We saw evidence during our inspection that the manager had arranged dates for some training sessions to be given.

People said that they enjoyed the food. One person told us how much they had enjoyed their lunch, particularly the pudding. Another person commented to us, "The food is very good. We get plenty to eat and drink." Only one person felt that there could be an improvement for their own tastes and needs. They told us, "Sometimes the vegetables aren't done enough for me because I don't have any teeth." However, they were satisfied with the food on offer.

People told us that they could choose where they ate their meals. One person told us how they liked to have their meals in their room. They said the food was always hot when it arrived. We asked whether they had enough to eat and drink. They told us, "Yes, plenty and I can always ring for more if I want it." They went on to tell us, "To be honest, breakfast and lunch are good enough that I don't always want much later in the day.

Before lunch was ready we saw that staff offered people either a glass of juice or sherry and people told us they enjoyed that. We saw that people using the main dining room received their meals first. They were not left sitting at the table waiting for very long. Other people sitting in the lounge also received their meals quickly. We noted that, in both areas, staff asked people whether they would like gravy, salt and pepper and made this available. One person told us how much they liked mint sauce if there was lamb on the menu and could have that. They also told us that staff knew they liked tomato ketchup and would get that for them if they wanted it. However, we saw that staff served people's main meals already plated up. This meant that people did not have the option to serve themselves and select their vegetables.

Staff weighed people to monitor them for any unplanned change in their weight. The staff took any necessary action if there were any concerns about unintended weight change. We found that staff completed people's nutritional assessments accurately, which meant that they monitored the risk of people not eating enough.

We saw that people were given support by staff with meals and drinks if this was required. However, equipment to help people maintain their independence was not always available. One person was served drinks in two different types of cup, one of which they had difficulty using. We also saw that this person had

difficulty eating with the cutlery and crockery given to them with their lunchtime meal. Staff members intervened to assist the person on both occasions, but we noted that adapted cutlery or plate guard, which might have made the process easier for them, were not available.

We saw that this person may have had difficulty swallowing their food as they coughed continually throughout their meal and another person did not eat well. We discussed both of these concerns with staff, who advised that they would pass the information on so that they could be referred to appropriate health care practitioners if appropriate.

People told us that they usually saw healthcare professionals when they needed to and that staff arranged this quickly. "When I couldn't hear they took me to the doctors to sort it out. They will arrange for appointments if I don't feel well." The person was wearing glasses so we asked whether they saw the optician. They told us, "I haven't seen anyone but I haven't asked. I'm sure they would arrange it if I did." Another person told us that the chiropodist came to see them regularly.

One person became unwell during the first day of our inspection visit. Staff were alert to a change in their behaviour, which they said was out of character. The manager checked the person's wishes in relation to their health and followed this up. They also made arrangements to seek emergency medical advice to promote the person's health and welfare. Records showed that people received advice from a variety of professionals including their GP, district nurses and specialist nurses. We concluded that staff helped people to access the advice and treatment of health care professionals.

Good

Is the service caring?

Our findings

People spoke positively of the way staff supported them, and about their approach. For example, one person told us how they often needed assistance during the night. They told us, "The staff never seem to mind. They are all very friendly." Another person said, "I like it here, I get on well with staff."

We spent time watching how staff interacted with people and found that they were kind, gentle and considerate towards people. We saw that people chatted with staff in an easy manner and there was lots of laughter and smiling between them. Staff showed concern for people's welfare and intervened promptly when people needed help. We were present when two people began to argue and staff members intervened when they heard this. They distracted one person and engaged the other in chatting about a book they had. This helped to calm the situation quickly.

We found that staff knew people well and that they were able to anticipate people's needs because of this. One person became anxious and distressed during our visit. Staff intervened promptly, offering reassurance that the staff would protect them and not let anything bad happen.

People told us that they were able to do what they wanted and that staff always gave them care and support in the way that they wanted. We observed how staff responded to one person asking if a staff member could help them. The staff member reassured them, "Of course I can." They assisted the person as they had asked and then checked again to make sure the person was comfortable. We heard people engaging with each other about the choice of music and television channel. One person told us that they chose where they spent their time in the home. They said that, if they did not want to be with others or join in the same things, they would go to their room and watch television or do their puzzles.

We saw that staff involved people in their care by talking to them about what they wanted and when they wanted this. One person was able to have a bath in the afternoon, which suited them better than the morning. Staff asked other people what they would like to do when they needed personal care and we saw that people were able to tell staff how they preferred their care and help to be given.

People told us that staff respected their privacy and dignity. One person and three visitors, said that they felt staff were always polite and respectful when they spoke. Visitors said that staff were always welcoming to them although they did not always know when they were coming and it was not always on the same day. They told us how staff always offered them a hot drink during their visit.

We saw that staff knocked on people's doors before entering rooms and announced themselves as they entered the room. During our visit we saw that personal care was given behind closed doors, people were dressed in clothing that was appropriate for the weather and staff were discrete when talking about personal subjects.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in July 2016 we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people received care when it was most convenient to staff members and not when the people needed or wanted it. Care records had not been updated when people's care needs had changed. There was also a lack of social stimulation and things for people to do. Following our inspection the provider told us that care plans had been updated but did not tell us what actions they had taken to address the other areas of concern.

During this visit we found that there had been some improvement in regard to the care that people received, the care records and activities throughout the day. People told us that staff looked after them well and they received the care they needed when they wanted it.

We spent time observing how staff cared for people and found that staff anticipated people's needs and were aware when people needed their attention more urgently. We saw that staff interacted with people in a positive way. Staff frequently walked around the home to make sure people had their care needs met in a timely way. When call bells were activated staff members attended to these quickly.

We spoke with staff members about several people and their care needs. Their descriptions showed that they had a good understanding of people's individual care needs and their preferences.

Assessments of people's care needs were completed before they went to live at the home. These were accompanied by social care assessments where available, which provided an overview of the person's abilities and what they needed help with, and a description of the circumstances leading to their living at the home.

Care plans were in place and had been updated since our last inspection to give staff guidance on how to support people with their identified needs such as personal care, nutrition and mobility needs. People's care records contained enough information about their lives, preferences, likes and dislikes and details about what they liked to do to keep themselves occupied. We saw that there was general guidance for staff, with some plans describing the physical support people needed in more detail. We also saw however, that some plans did not contain enough detail to guide staff in managing specific health needs, such as diabetes or catheter care. We spoke with staff members about people's diabetes care and they were able to describe the differences between three people's care needs. They had a clear understanding of each person's ability in this area and the actions that staff needed to take to help the person. However, despite this we found that there were errors in recording whether the support or supervision had been given.

We spoke with the manager about the information in people's care plans. They told us that they had started to rewrite people's care plans so that they contained enough information to fully guide staff. This meant that although staff members still did not have enough guidance to care for all of the people's needs properly, actions were being taken to address the shortfalls in care planning.

People told us that they knew there were activities on offer. One person said, "There's something on most afternoons I think. I don't always go down for things unless there's something I want to do." They told us that they liked to spend their time reading and commented, "They [staff] will get new ones (books) for me if I ask." They explained that they did like to join in some events and celebrations such as for Christmas. Another person told us how they enjoyed puzzles. They told us, "If I don't want to join activities I go to my room."

Some people were awaiting appointments to have their hair done and two people told us they were looking forward to that. Two other people were relaxing reading their newspapers in the lounge area. When staff put some music on with people's agreement, we saw that several people who had been quietly sitting in the lounge did start humming to themselves or singing along.

During our visit, a small group of people joined in with flower arranging at the large table in the dining room. Afterwards, they were engaged in discussing what were their favourite flowers and what they would like to see in the garden, as well as about plant pests and problems. We spoke with one staff member at the home who had held a cake decorating session. This had led to a discussion about sweets that people knew from childhood that were still available. The staff member told us that they had described the toppings to people who were not able to see them and people tasted them before deciding which to top their cakes with.

People told us they would be able to speak with someone if they were not happy with something. One person told us, "I know who I can speak to as there's one that comes around but I don't have any complaints." Another person told us of a complaint they had made recently about their uncomfortable mattress and that the manager was working to resolve this. The person had received a new mattress and said the next day that they had a good night's sleep.

A copy of the home's complaint procedure was available and provided appropriate guidance for people if they wanted to make a complaint. Records showed that the registered manager had acknowledged and responded to complaints, and they took appropriate action in response to the complaints to improve the quality of care provided.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in July 2016 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have effective systems in place to monitor the quality of the service. Following our inspection the provider told us that a comprehensive quality assurance system was in place, but had not been completed as there was no manager in post. These responsibilities would be transferred to other staff until a new manager was in place.

During this visit we found that there had not been enough improvement in the way these processes were completed to show that the provider had effectively monitored the quality of the service.

The provider's representative told us that their policy was for medicines audits to be completed every two weeks, although they were not able to show that this happened as expected. There were no completed checklists for medicines management since a previous manager left at the end of 2015. The provider's representative told us that staff were auditing medicines but recording this on the back of medicine administration record (MAR) charts. They were able to locate a small number dated as completed on 14 November 2016 but none since. These checks were not sufficiently robust to properly monitor how medicines were managed and to identify promptly whether there were concerns about administration or recording practices. The entries on individual MAR charts for November 2016 just recorded that an audit for the person had taken place and "…appears correct." Systems were not robust in ensuring that people always had access to the medicines prescribed for them and that medicines records were accurate.

We found that although fire safety issues had been identified, inadequate action had been taken to ensure these issues were corrected. The provider had been alerted to concerns with fire safety systems in October 2016 by the fire safety officer and prior to this by their own fire safety consultant. They had been issued with a deficiencies notice by the fire safety officer and had initially been given until February 2017 to make repairs. This timeframe was extended when the work had not been completed. We found these same issues when we visited, after the fire safety officer had carried out a revisit earlier in the month to check whether the provider had taken the appropriate action. This meant that the provider put people at continued risk by not taking appropriate action to remedy areas where there were concerns.

The manager had completed audits of equipment, the environment and a brief audit of people's care and whether they were happy and received the care they needed. These provided a basic assessment that identified issues and developed plans of the action needed to address them and by whom. However, we found that neither staff who had completed medicines audits, nor the provider's representative had shown the manager these records or how they should be completed.

We found that although there had been some improvement in the monitoring of systems, this had only been started very recently. For the period between our last inspection and December 2016 there had been a lack of managerial and provider oversight. This meant that appropriate action to reduce the risks to people in the event of fire were not taken. It also meant that medicines management was not monitored. This led to a continuation of the poor practice that we saw during this visit, so that people did not always received their

medicines, as there continued to be a lack of effective monitoring. For one person records were too unclear to ascertain whether they had missed only one dose or four doses of a vital cardiac medicine, which put the person at risk of worsening health problems.

A log kept of details about people who had fallen while living at the home showed information about this had been collated. However, this had not continued past March 2016. We looked at accident and incident records for November and December 2016 and January and February 2017 and found that just over 40 percent were in relation to one person. We also identified that just over 40 percent occurred in the afternoon or early evening. The provider's representative told us that they had employed an additional staff member to work at teatime, to assist staff with drinks and meals. However, there had been no information to show whether this had impacted positively or negatively on the number of falls occurring at this time. This meant that there was no analysis of trends or themes, or whether actions could be taken to reduce risks to people.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's views of the running of the home were obtained in a survey at the end of 2016. The most recent survey was still being collated. We looked at the responses, which showed a very positive result overall. It showed that people were happy with the care they received.

The manager had been in the position since December 2016 and confirmed that they were in the process of applying for registration with the Care Quality Commission (CQC). The last registered manager left the position in November 2014, although their registration with us was not cancelled until February 2016. The provider's representative confirmed that a manager had been employed for two weeks between February and December 2016 but had left the position.

One person told us that they knew who the manager was and that they saw them around the home. Staff members told us that the manager was approachable and that they could rely on them for support and advice. One staff member told us that the manager had made a difference since working at the home.

Staff members told us that although they had different roles, they all worked as part of the same staff team and their goal was to care for people well. They said that working at the home was very teamwork orientated. Staff told us that they had monthly meetings, such as team meetings, to discuss changes around the home. They said they were able to raise concerns. A staff said that they were also able to contact the provider's representative is they had any concerns. They knew about the whistle blowing policy and where this was kept.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider did not take adequate action to ensure that people always received their medicines as prescribed.

The enforcement action we took:

Positive condition was imposed to ensure the registered provider took the appropriate action to monitor medicines administration and recording, and took action to rectify errors as quickly as possible.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not taken adequate actions to monitor the service or risks to people.

The enforcement action we took:

Positive condition was imposed to ensure the provider took the appropriate actions to monitor the service provided and the risks to people on a regular basis.