Priorcare Homes Limited

Fernlea

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We completed an unannounced inspection at Fernlea on 21 November 2016. At the last inspection on 23 December 2015, we found that the service was meeting the regulations, but some improvements were still required.

Fernlea are registered to provide accommodation with personal care for up to 13 people. People who use the service may have physical disabilities and/or learning disabilities. At the time of the inspection the service supported 13 people.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Risks to people's health and wellbeing were not consistently identified, managed or followed by staff to keep people safe from the risk of harm.

People were not always protected from the risks of abuse because appropriate and timely action was not taken by the registered manager when concerns were raised and the appropriate authorities were not always informed of potential safeguarding concerns.

We found that medicines were not administered and stored in a consistent and safe manner and they were not always administered as prescribed.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that poor care was not identified and rectified by the registered manager and provider.

People's care records did not contain an up to date and accurate record of people's individual needs. This meant that people were at risk of receiving inconsistent care.

Systems in place to monitor accidents and incidents were not being followed or managed to reduce the risk of further occurrences.

Staff told us they received training. However, we found that some of the training they had received was not effective. There were no systems in place to ensure that staff understood and were competent to support people safely and effectively.

We found people were not consistently treated with dignity when receiving support.

When people did not have the ability to make decisions about their care, we saw the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were not consistently followed. These requirements ensure that where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. We found that staff were not always aware of people who were subject to a DoLS and where best interest decisions were made it was not always clear who had been involved in the decision making process.

Advice sought from health and social care professionals was not always followed to ensure people's health needs were met effectively.

We found there were not always enough staff available to deliver people's planned care and staff were not always available to supervise people with their nutritional needs.

People told most staff treated them in a caring way. However, some people felt that they were not listened to and choices were not always promoted.

Improvements were needed to ensure that people were able to access hobbies and interests that were important to them. We found that improvements were needed to ensure that staff were available to support people with hobbies and interests when the dedicated worker was unavailable.

Effective systems were not in place to investigate complaints and act upon people's concerns in a timely manner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's risk were not managed to protect them from the risk of harm.

People were at risk of abuse because concerns raised were not dealt with in a timely manner and reported to the appropriate authorities to protect people from the risk of further or potential harm.

Medicines were not managed in a safe way.

Improvements were needed to ensure there were enough staff available to provide care that met people's assessed needs. Safe recruitment practices were not always followed to protect people from potential harm.

Is the service effective?

Inadequate

The service was not always effective.

People were at risk of receiving inappropriate care because they did not always have the skills and knowledge to understand how people needed to be supported effectively.

When people did not have the ability to make decisions about their care, we saw the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were not consistently followed.

Advice received from other health professionals had not always been acted on to ensure people were supported in line with their guidance.

People were happy with the food provided. However, staff were not always available to provide supervision when required.

Is the service caring?

Inadequate

The service was not caring.

People's dignity was not always upheld or respected by staff.

People's choices in care were not always listened to and promoted.

Some staff were caring, but people felt that staff were not always able to provide care that was focused on their wellbeing.

Is the service responsive?

Inadequate

The service was not responsive.

People were at risk of receiving inconsistent care because records were not reviewed and updated when people's needs changed.

Effective systems were not in place to investigate complaints and act upon people's concerns in a timely manner.

People were not always supported to access hobbies and interests to meet their emotional and social wellbeing.

Is the service well-led?

Inadequate

The service was not well led.

Systems in place to monitor the quality were not effective and concerns identified at the inspection had not been identified by the registered manager.

Records did not contain accurate and up to date information to give staff guidance on how people needed to be supported safely and effectively.

The provider did not have a clear overview of the service and systems in place to ensure that the regulated activity was being carried out as required were not effective.

Fernlea

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 was 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 21 November 2016, and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, we reviewed information we held about the service. This included notifications about events that had happened at the service, which the provider was required to send us by law. For example, serious injuries, safeguarding concerns and deaths that had occurred at the service. We had also been made aware of concerns about the way the provider carried out the service.

We spoke with five people who used the service, three members of staff, the registered manager, chief executive and the provider. We observed how staff supported people throughout the day and how staff interacted with people who used the service.

We viewed seven records about people's care and eight people's medicine records. We also viewed records that showed how the service was managed, which included medicines audits, training records, incidents, complaints, staff recruitment records and staff rotas.

Inadequate

Is the service safe?

Our findings

We found that people's risks were not managed or mitigated to keep them safe. For example; we saw one person had been assessed as at risk of choking and they were supported with a soft diet. The records showed this person had visited their GP because they had been coughing frequently. The records from the GP visit advised staff to supervise this person when they were drinking while they were experiencing heightened periods of coughing. During the inspection, we saw this person was left unsupervised in the dining area in the morning with a drink of tea and their chest was making a gurgling sound and they were constantly coughing. We asked staff what support they needed to provide this person and if there had been any recent changes with their risks. Staff were not aware that this person needed to be supervised with their drinking when their chest had deteriorated or when they were coughing more. Some staff told us that the person had deteriorated recently and some staff told us that there had been no change in their health and wellbeing. The eating and drinking care plan and breathing care plan we viewed had not been updated and did not include this new information from the GP, which had been recorded in the professional notes. We also saw that the nutrition risk assessment had not been updated to include this new information. There had been no intervention or referrals to the speech and language therapist about this person's deterioration. This meant that this person was at risk of harm because they were not supported with their nutritional risks and their risks had not ben mitigate to keep them safe.

We saw that one person's skin integrity care plan showed that they were at risk of skin damage and they had had been prescribed topical creams to be used to protect their skin from damage. The Medication Administration Records (MARs) we viewed showed that the topical creams had not been administered for a two week period. The skin integrity plan also showed that this person needed to be supported with four hourly turns to maintain their skin integrity. The turning charts we viewed showed that this person had not received their four hourly turns on five occasions, which meant we could not be assured that turns had been completed as planned for. The daily records we viewed showed that this person's skin had deteriorated in this period and the body map showed that this person had two areas of broken skin. We asked the registered manager if they could explain why this person had not received their topical creams as prescribed and we were told, "It is because the cream has been out of stock for this period. We have had some problems this month with the chemist being unavailable". The manager told us that the district nurse had been contacted when they recognised that the person's skin had deteriorated, but they had not ensured that this cream was available to protect their skin from damage. This meant that this person had suffered harm because they had not received their topical creams as prescribed and their assessed risks had not been mitigated to protect them from harm.

We viewed the continence care records for one person who had a stoma bag in place. The records showed that the stoma bag had burst on eight occasions in a three week period. The stoma care records showed that this person's stoma bag was inconsistently checked by staff and showed that on some days their stoma bag was checked three times a day and on other days their stoma bag was checked twice. The records showed that the stoma bag had only been checked twice on the days that the stoma bag had burst. Staff we spoke with about this person's continence care gave inconsistent accounts of the support they provided. The care plans and risk assessments we viewed had not been updated or reviewed and did not state that

there was a risk of the bag bursting. There was no clear guidance for staff to follow on how often this person's stoma bag needed to be checked and emptied. This meant that this person had not been supported to manage the risks associated with their continence and their plan of care did not contain sufficient up to date information to give staff guidance on how to manage this in a safe and consistent way, whilst protecting this person's dignity.

We found that medicines were not managed in a safe way. We found that some 'as required' protocols did not contain sufficient information to give staff guidance as to when people needed their 'as required' medicines. For example; we saw that one person was prescribed lorazepam to help with periods of agitation. The 'as required' protocol stated that this needed to be administered when the person had been agitated for a while. This did not give clear guidance of the amount of medicine that was needed as the records stated half or one tablet, but did not say when or why the higher dose would be needed. There was no guidance for staff to recognise the level of agitation that may trigger the administration of the 'as required' medicine. Staff we spoke with did not tell us this person needed medicine to reduce periods of agitation. This meant that there were not clear guidelines in place to ensure that this person was supported to have their 'as required' medicine in a safe and consistent way.

We checked the balance of stock that the home held against the balance recorded on the Medicine Administration Records (MARs) for eight people. We found that the stock did not balance, which meant that we could not be assured that people had received the medicines they needed. For example; the MAR for one person stated that they needed a certain medicine to be administered at night every other day. The MAR showed that this person had been administered this medicine on three consecutive days. We checked the level of stock of this medicine held at the home against the amount recorded on the MAR. We found that this did not balance and there were two more tablets in stock than recorded on the MAR. We asked the registered manager about this and they were unable to give an explanation about the errors in the medication. This meant that we could not conclude that this person had received their medicines as prescribed and there was a potential risk to their health and wellbeing. This meant that we could not be assured that people had received their medicines as prescribed.

We found that medicines were not always stored securely. We saw that medicines were stored in a room in a locked trolley. However we found that the room was open throughout the inspection and we found the keys to the medicine trolley had been left on top of the trolley. Some people who used the service were independently mobile and other people were able to move around the service using various mobility aids. There was a risk of harm to people because medicines were not stored safely.

The above evidence shows that people's risks were not planned, monitored or mitigated in a way that kept them safe from harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We viewed records of incidents that had occurred at the service. We found that incidents had not always been acted on to safeguard service users from abuse in a timely way. For example; we saw concerns had been raised by a person who used the service which stated that another person had walked in on them whilst they were in the shower. We spoke with the person who told us that they felt unsafe when they had a shower and they had told the management and staff about this on numerous occasions but the other person had continued to walk in on them when they were in the shower. The incident records showed that a sign had been put on the door and the registered manager and staff had spoken to the other person and asked them not to go into the shower room when it was in use and the sign was displayed. We saw further incident records, which showed this had continued to happen. The person told us and we saw an incident record that showed the person had contacted the police because they did not feel safe in the shower. We

saw that after the concerns had been reported to the police, action was taken by the registered manager to ensure that the lock was changed on the door so that the door could be locked when the shower room was in use. We asked the registered manager why the lock on the door had not been fitted earlier. We were told there was a lock on the door but it was not used previously as it was not safe because staff would not be able to access the shower room in an emergency. We asked why the lock had not been replaced earlier, but the registered manager was unable to provide an explanation for this. This meant that this person had not been safeguarded from possible harm because safe and appropriate actions had not been put in place in a timely manner to mitigate any potential abuse.

We found that incidents of alleged abuse had not always been reported to the local safeguarding authority to ensure that people were protected from possible harm. For example; we saw an incident form, which showed there had been an incident between two people who used the service. The records showed that one person had sustained some minor injuries of red marks to their thigh, wrist and forearm. We saw that the registered manager had made a phone call to the commissioning officer of the local authority, but the local safeguarding team had not been informed of the incident. This meant that the registered manager did not understand their responsibilities and procedures to report safeguarding concerns. We saw an incident form had been completed for one person which showed that the person's dentist had raised concerns that staff had not assisted them to maintain their dental hygiene effectively. We saw that the deputy manager had recorded that all staff had been informed that they must ensure people are supported with their oral hygiene. However, this incident of alleged neglect had not been reported to the local safeguarding authority for their consideration and investigation. This meant that incidents that constituted possible abuse had not always been reported to the relevant authorities to assess whether an investigation into the alleged abuse was required and people were not protected from possible harm.

The above evidence shows that people were not safeguarded from the risk of abuse and appropriate action was not taken to prevent possible harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that some people had to wait for staff support. For example; one person had become agitated and was supported to their room to help their anxieties. Staff we spoke with told us that they usually supported this person to return to the lounge room after approximately five minutes. One staff member said, "We normally support this person back into the lounge once they have calmed down, but it has been longer today because we [the staff] have all been busy toileting people". This meant that there were not enough staff available to support this person with their assessed needs in a timely manner.

We saw the provider had recruitment procedures. Staff had undergone checks to ensure they were of good character and references from previous employment had been sought. However, we found that a staff member had a positive DBS on their file. We asked the registered manager if there had been a risk assessment carried out to ensure that this staff member was suitable to provide support to vulnerable people. The registered manager told us they had completed a risk assessment. However, they were unable to find the completed risk assessment to provide evidence that they had taken action to mitigate and manage risk to people. This meant improvements were needed to ensure that people were supported by suitable staff.

Inadequate

Is the service effective?

Our findings

Staff told us that they had received training to carry out their role. However, we found that some staff had not received training to enable people to be supported effectively. For example; we spoke with three staff about their understanding of Deprivation of Liberty Safeguards (DoLS). Two members of staff were unable to explain to us what DoLS were and how they needed to support people who were subject to a DoLS authorisation. One staff member said, "I don't know about these". Another member of staff said, "I know about MCA, but I'm not sure about DoLS or who has one in place". We saw that the service had a training matrix in place. This showed that the three staff that were on duty on the day of inspection had not received training to understand what DoLS meant and why these were needed for some people. We also found that there were gaps in staff training for other areas such as; safeguarding vulnerable adults, person centre care and pressure care. We identified at the inspection that staff had not followed the correct procedures for reporting safeguarding concerns and people were not always supported in a safe way with their pressure care.This meant that people were at risk of not being supported safely and effectively because staff who provided support to people with DoLS in place did not have the knowledge and skills required.

The above evidence shows that staff were not sufficiently trained to meet people's needs and to keep people safe from the risk of harm. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that the registered manager had made referrals for a Deprivation of Liberty Safeguards (DoLS), where they felt people had restrictions in place to keep them safe. However, staff we spoke with were not aware of one person who had a DoLS in place to keep them safe in the least restrictive way. This meant that this person was at risk of receiving inappropriate support that was not in their best interests because staff were unaware of how this person needed to be supported in the least restrictive way.

People told us that they consented to their care and staff asked their permission before they provided support. However, one person who had capacity to make decisions about their care told us that staff did not always respect their decisions. They said, "Some staff are not happy when I refuse care, but I understand the risk if I choose to refuse. It's my choice though". This meant that people felt that staff did not always take people's consent into account.

Some people were unable to understand some decisions about their care and we found staff had limited understanding of their responsibilities under the Mental Capacity Act 2005 (MCA). Staff we spoke with were unable to give full explanations of what the MCA meant for people and told us they had limited understanding of the MCA. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act

requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw mental capacity assessments had been carried out when people lacked capacity to make certain decisions, but it was not always clear in the records how the decision had been made and which professionals had been involved to ensure that decisions were made in people's best interests.

People told us that they were able to access health professionals when they needed to, such as doctors, chiropodists and opticians. However, we saw that when advice sought when people's health had deteriorated was not always followed. For example; we saw in the professional's records that one person's G.P had advised that they needed staff supervision when drinking due to their risk of choking. Staff we spoke with were not aware that this was required and we observed this person drinking on their own unsupervised. The care records we viewed did not contain the guidance from the professional and this person was at a high risk of choking because staff were not following professional advice. This meant that advice sought from professionals had not always been followed to maintain people's health, safety and wellbeing.

People we spoke with were happy with the food. One person said, "The food is very good and I can have something different if I don't like what is on offer". Another person said, "I'm happy with the food, it's all good". We observed people's experiences during lunch. People who needed assistance to eat were provided with one to one support. However, we saw that people who were able to eat independently were left to eat with very little interaction from staff during their lunch. We found there were long periods of time where staff were unavailable in the dining areas to monitor people's eating and drinking where required. This meant that people were not supported by staff to ensure they ate and drink sufficient amounts whilst taking into consideration their nutritional risks.

Inadequate

Is the service caring?

Our findings

We found that people were not always treated with dignity and respect. For example, two people we spoke with told us that there were certain members of staff that shouted at them and made them feel upset. One person told us that staff spoke with them in a disrespectful way and they had overheard staff talking about them. This person told us that certain staff were very sharp with them and would take their breakfast into them without saying "Hello or good morning", They said, "Certain staff are not very nice with me, they don't even say 'good morning' and I think to myself what have I done. It's not a very nice feeling". Another person told us how a member of staff had spoken with them in a disrespectful and undignified manner when they wanted to get past them. This person said, "Certain members of staff upset me because of the way they talk to me. They [staff} say 'Oi, back in your room' which makes me feel upset". This meant that people did not always feel they were treated with dignity and respect.

People gave mixed views about their experiences of how their care was delivered. Some people we spoke with said most staff were caring towards them. However, some people felt that some staff were not caring. For example; one person told us that they did not always feel listened to and staff were not happy if they refused to be supported. This person said, One staff member keeps telling me to put my boot on, but I don't want to. I know if I don't I might get hurt or bruised but it's my choice as I'm 50 years old, but they don't listen to me". This meant people were not always supported by caring staff that respected people's wishes.

The above evidence shows that people were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People also told us that staff were unable to spend time with them 'just chatting' because they were busy and didn't have time. One person said, "The staff are okay and help me with things, but it would be nice if they could have the time to talk to me about things". We saw that staff were rushed and were unable to spend dedicated time with people because they were busy carrying out support tasks. This meant that staff were not always able to provide care in a way that met people's emotional wellbeing.

People told us that they were offered some choices in the way they received their care, but other choices were not made available to them. One person said, "I get up when I want to and I like to choose my own clothes". However, this person also told us that they were not given a choice of television programme. They said, "We come into the lounge and the television is on already. I don't choose, I'm not sure what this is but the staff choose what is on the television". We saw that people were sat in the lounge facing the television on the day of the inspection, but staff did not ask people what they wanted to watch. his meant that people were not always supported in a way that met their individual needs.

Inadequate

Is the service responsive?

Our findings

People told us that they accessed the community with support from staff such as, shopping trips and clubs. However, we found that people were not supported to maintain their emotional wellbeing within the service. For example; one person told us that they would like to go out more and they used to go out twice a week but this had reduced to once a week. Another person told us that there was nothing for them to do at the service. They said, "There isn't a lot to do. Family visit sometimes but there's nothing else really". We saw people watching television, asleep in the lounge area, but we did not see staff supporting people with interests or hobbies.. We saw that one person became unsettled and displayed behaviour that challenged. This person's care plan stated that sensory activities in their room often settled them, but this was not carried out by staff and the person was left in their room for a period of time without any stimulation. We did not see that there were activities for people to keep them occupied or to maintain their emotional wellbeing. The registered manager told us this was because the activity worker was not available on the day of the inspection to provide activities for people. This meant that improvements were needed to ensure that the provider had a contingency plan in place to enable people to access hobbies or interests when the designated staff member was not available.

We saw that some reviews of people's care were out of date and where people's needs had changed the records had not been updated to reflect this. For example; one person's skin condition had changed and staff told us that this person needed to be supported to have bed rest to help their skin. However, the care plans and risk assessments had not been updated to reflect their change in needs and we found that this person was receiving inconsistent care. Staff told us how they needed to support a person who displayed behaviour that challenged. Staff gave inconsistent explanations of how this person needed to be supported. We found that the care plans did not contain sufficient information for staff to follow to support this person in a way that met their individual needs. For example; one staff member told us that this person needed to spend time in their room for approximately five minutes and another staff member told us that this person needed to spend approximately 30 minutes. This meant that people were at risk of receiving inconsistent care that was not responsive to their needs.

We found that people's care records did not contain an accurate reflection of the supported they required when their needs had changed. For example; the professionals' records we viewed showed that one person had received advice from the Occupational Therapist regarding the support they needed from staff to move safely. The advice stated that the person needed to be supported to move on their left side when they were being transferred to their wheelchair. The mobility and dexterity care plan we viewed did not contain this up to date information for staff to follow. This meant there was a risk of inconsistent support being provided there were not up to date records for staff to follow. We viewed another person's bath/shower care plan and found that the care plan had not been updated for six months. This person's needs had changed and it was important that the shower room door was locked whilst they used the shower to prevent another person who used the service accessing the shower room. There had been no updates to inform staff that the door of the shower room now needs to be locked to protect this person from the risk of harm. Staff we spoke with knew how to support this person, but we were told by staff and the registered manager that the service used agency staff to cover shortages. There was a risk that this person would not be supported to protect their

safely by agency staff because up to date records were not available. This meant people were at risk of receiving inappropriate and inconsistent care that did not reflect their needs.

The above evidence shows that people did not always receive care that was met their individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they knew how to complain and who to complain to. However, we found that people's complaints were not always acted on in a timely manner. For example; we viewed a complaint from a person who used the service regarding their experiences when taking a shower. We spoke with the person who told us, "I've made a lot of complaints. I feel that I am not listened to when I complain, nothing changes and I feel like staff and the management think I am causing trouble". Another person had relayed their concerns to us about the support they received from staff. We spoke with the registered manager about these concerns who told us that they had spoken to staff about this. We did not see records for all of the complaints we were made aware of and how this had been investigated and acted on by the registered manager. This meant that there were not effective systems in place to manage and act on complaints from people.

The above evidence shows that effective systems were not in place to act on complaints about the service provided. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We viewed monthly medicine audits that had been carried out over a three month period. We saw the audits had identified that the stock of medicines held at the service did not balance with the Medicine Administration Records (MARs). The audits we viewed did not show what action had been taken to prevent future errors. At our inspection, we found that errors with medicines were still occurring. For example; we found that people were not receiving their medicines as prescribed, which placed them at risk of harm to their health and wellbeing. The registered manager was unable to explain what action had been taken to ensure medicines were managed safely. We were not assured that appropriate action had been taken to ensure that medicines were managed safely and people were protected from harm. This meant that the monitoring and management of medicines were not effective in mitigating risks to service users.

We saw that records did not contain an accurate and up to date account of people's needs, which meant people were at risk of receiving inconsistent support. We found that the systems in place to ensure care records were kept up to date were not effective. We feedback our concerns to the registered manager about the accuracy of the care records. We were told that the care plan audits had not been completed and had fallen behind because the deputy manager had recently left and they had been unable to carry out the audits to ensure people's were receiving appropriate care because they had not had enough time. This meant that the system in place was not effective and people were at risk of inappropriate and inconsistent care.

We found that the system in place to ensure staff were trained sufficiently to meet people's needs was not effective. For example; Staff we spoke with had a poor knowledge of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). We saw that the training matrix was reviewed by the provider on 07 September 2016, which had recognised that staff had not carried out their required training and the registered manager had informed staff that this needed to be completed. The up dated training matrix supplied by the registered manager at the inspection showed that there were still gaps in DoLS training and action had not been taken to ensure staff were sufficiently trained and competent to carry out their role. The registered manager had not undertaken competency checks with staff to ensure that the training they had received was effective. This meant that people were at risk of receiving inappropriate care because staff were not trained appropriately and the system in place to monitor staff training was not effective.

We viewed incident and complaints monthly audits that had been completed by the provider for the period June 2016 to August 2016. We found that trends with incidents and complaints had not always been identified and acted on appropriately. For example; we found that two incidents of alleged abuse had not been reported to the local safeguarding authority. These incidents were detailed on the audit and had been signed off by the provider as appropriate action taken to deal with the concerns. The provider had not identified that the registered manager had not reported these concerns to the local safeguarding authority as required. This meant the audit carried out by the provider was not effective in ensuring that the registered manager had taken appropriate action to manage the service effectively.

We saw that a quality indicator report had been completed by the provider on the 3 October 2016. This had

been completed to show how the provider was meeting Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance. We found that the finding of the provider did not match what we identified at the inspection. For example; we saw that the quality indicator stated that care plans had been reviewed monthly, but we found that care plans were not up to date and changes had not been made where people's needs had changed. We saw that the quality audit stated that where audits had been completed there were actions in place to be followed up at future audits. However, we found that the medicine audits did not contain actions where concerns had been identified to prevent future occurrences. This meant that the system in place to identify good governance was not effective and did not provide a true overview of the effectiveness of the audits in place to monitor the service.

The above evidence shows that effective systems were not in place to monitor, manage and mitigate risks to people and protect them from harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.