Milkwood Care Ltd

Milkwood House Care Home

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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 9 March 2015 and was unannounced. Milkwood House Care Home is registered to provide residential care for up to 43 older people who may experience dementia. At the time of the inspection there were 33 people using the service.

The service has a registered manager. 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.

Most people told us they felt safe. However, people were not adequately safeguarded from the risk of abuse. Incidents had not been identified as potential

Summary of findings

safeguarding alerts and reported to the relevant authority, which left people at risk. Staff did not fully understand their safeguarding responsibilities to enable them to protect people.

Risks to people were not always assessed or there were not always plans in place to manage them. People had not always been monitored after experiencing a fall. People had not always been weighed or their risk of malnutrition screened. Adequate action was not taken by staff when they lost weight. People were at risk from complications following falls and from malnutrition.

People's medicines had not been stored or disposed of safely. Stocks of medicines did not always match records. People's medicines had not been managed safely. People were at risk of receiving inappropriate medicines.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Some people had DoLs in place, but applications had not been submitted by the provider for all relevant people. One person's care had been provided by three staff on occasions due to their behaviours which challenged staff, with no legal safeguards in place. People had not always been protected from the risks of unlawful control.

Staff underwent recruitment checks but had not provided a full employment history. Staff had only been required to provide their last 10 years history and there was no explanation of their employment history prior to this date. This did not fully protect people from the employment of unsuitable staff. Staff had not all completed an effective induction to their role or all required training to meet the needs of people. Staff had not received sufficient supervision. People were cared for by staff who had not been supported effectively.

The registered manager had not operated the audit and reporting processes effectively in order to identify issues in relation to people's safety and the quality of their care. They had not given due regard to people's feedback. People's records did not contain all of the required information for staff to provide their care safely. These records could not always be readily located.

Not all staff had consistently demonstrated the provider's values. The culture of the service was not reflective or analytical of incidents and practices. This resulted in ineffective processes and procedures not being identified or challenged. People's care was negatively impacted upon. Staff had not been well-led by the registered manager. The provider took prompt action following the inspection in response to the issues identified.

Staff had not consistently followed best practice in relation to the Mental Capacity Act (MCA) 2005 Staff were due to receive further training imminently. People were at risk of not having their rights upheld as not all staff understood the requirements of the MCA 2005.

Staff had not always ensured referrals to other services such as mental health teams were made promptly in response to people's needs.

Records documented people had been involved in their care planning. However, people and their relatives told us they had not felt involved. People's records contained information about their preferences about their care. However, this information had not been consistently reflected in their care plans, to ensure their care provision reflected their preferences. People's care plans had not been regularly reviewed with them or their relatives, to enable them to make changes when required.

People who experienced dementia did not consistently receive information in a manner that met their needs; this did not always enable them to make choices. Staff understood how to uphold people's privacy and dignity. However, one person's privacy and dignity had not been upheld.

People were cared for by staff who they told us were caring towards them. One person told us "The girls are lovely; they come in and chat; take me to the lounge; give me drinks." People were seen to be spoken to by staff in a kindly and caring manner.

People had access to a complaints policy and felt able to complain. Even though they had been informed of how to complain they did not always recall whom to complain to or how. People would have benefited if this information was more accessible.

The service was clean. Although not all staff had completed infection control training they followed the provider's guidance. People were protected from the risks of cross-infection.

We found a number breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Summary of findings

which correspond to 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.

Summary of findings

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.

There had been a failure to identify or report potential safeguarding incidents to the relevant authority. People were not adequately safeguarded from the risk of abuse.

Risks to people had not always been identified or managed to ensure people were safe.

People's medicines were not managed, stored or disposed of safely.

The recruitment process did not ensure all of the required evidence in relation to staff was available, to protect people from unsuitable staff.

There were sufficient staff to meet people's needs but there had been a lack of flexibility in staffing when people's needs had increased.

People were kept safe from the risks of cross-infection.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received adequate induction, training or supervision to ensure they were able to provide people's care safely to the required standard.

People had not been adequately protected against the risks of malnutrition or dehydration.

Where people were subject to restraint or a form of control was used in their care this was not always legally authorised.

The requirements of the Mental Capacity Act 2005 had not always been met consistently; staff were due to undertake training. People's rights may not have been upheld as not all staff had received training.

People's healthcare needs had been met but staff. However, staff had not always made referrals promptly to the mental health team in response to changes in people's needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their relatives had been consulted about their care plans, however, they reported not feeling involved.

The provision of people's care had not always consistently promoted their privacy and dignity.

People told us they experienced positive relationships with staff.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People provided information about their preferences but this information had not always been incorporated into their care plans. People's care may not have been provided in accordance with their preferences.

People and their relatives had not had the opportunity to be involved in reviews of their care. Therefore they could not review the content of their care plan.

People's needs for social stimulation were met through a programme of social activities.

People had access to a complaints policy and complaints had been responded to by the registered manager.

Is the service well-led?

Inadequate

The service was not well-led.

Audit systems had not been used effectively to monitor the quality of the service people received. Comments had not always been listened to and incidents had not been analysed. This left people at risk of harm and poor quality care.

People's records were not always complete and could not always be located promptly, which placed people at risk of inappropriate care.

Not all staff had consistently upheld the provider's values. The culture of the service did not encourage staff to reflect upon incidents and practice and learn from these.

The registered manager had not carried out their role and responsibilities consistently to ensure people received safe and high quality care.

Milkwood House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 9 March 2015 and was unannounced.

The inspection team comprised of two inspectors, a pharmacist and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of people living with dementia.

We carried out this inspection in response to a concern we had received about the care people received at Milkwood House Care Home. We did not request a Provider Information Return (PIR) at the time of our visit as the provider would not have had time to complete one. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We obtained this information during the inspection. Before the inspection we reviewed information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law. We spoke with two social services commissioners of the service and a social worker. Following the inspection we spoke with a nurse. None of the professionals we spoke with had any concerns about the service.

During the inspection we spoke with 17 people and two people's relatives. Not everyone who used the service could speak with us about their experiences as some people experienced dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. During the inspection we spent time observing staff interactions with people. We spoke with the registered manager, deputy manager and seven staff. Following the inspection we spoke with the group operations manager and the provider.

We reviewed four people's care records, four staff recruitment and induction records and other records relating to the management of the service.

The service was previously inspected on 17 October 2013 and was found to be compliant.

Inadequate

Is the service safe?

Our findings

People told us they felt safe, however, people had unexplained bruising. There had been incidents where people's rooms had been entered by another person, causing them distress. These events had not all been documented as incidents, reviewed or given consideration by staff as to whether a referral to the local authority safeguarding team was required. One person had hit another; this was not referred to safeguarding by staff. A person's relative reported to the registered manager seeing unexplained bruising on their relative. This was not adequately investigated by the registered manager to safeguard this person. The registered manager told us no referrals had been made to safeguarding. We noted no referrals had been made in records we looked at.

Staff were made aware of the principles of safeguarding as part of their induction. However, only 8 staff out of 22 had completed the provider's safeguarding training. One staff member confirmed they had completed this training but was unable to demonstrate their understanding. People were not safe as staff did not fully understand their role and potential safeguarding incidents had not been identified or reported to the relevant authority. Following the inspection we reported our concerns about people's safety to the local authority.

The provider's failure to ensure people were adequately safeguarded and to respond appropriately was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities).

People's families, their GP or social services had not always been informed of incidents. Staff understood the incident reporting procedures but told us they were not 'Set in stone.' People were not safe as staff had not always followed procedures and documented all incidents, to enable them to be investigated and action taken to prevent future harm to people.

When people experienced a fall their welfare and safety post fall had not been adequately monitored by staff. There was no procedure to guide staff in relation to how they should monitor people following falls. One person had fallen resulting in a lump on their head. This person could have sustained a head injury but no monitoring took place to identify if medical assistance was required. People's falls care plans and records were not always updated after they had fallen, which placed them at risk of complications or further falls.

People were breakfasting in the lounge or dining room and at times there were no staff present. This left them at risk of not receiving timely assistance if they were to choke. One person could not use their call bell and the deputy manager told us staff checked on them regularly, to ensure their welfare and safety. There was no care plan to provide guidance for staff in relation to these checks or records to demonstrate they had been checked. This person was at risk of not being monitored and having their needs met. A person was at risk of developing a pressure sore but there was no care plan to manage this risk. Another person's assessment indicated they were at risk of developing pressure sores and they had an electric pressure relieving mattress. There was no care plan to provide staff with written guidance about how this risk was to be managed. People were not safe as either risk assessments had not been completed or where they had been there was no risk management plan.

The provider's failure to plan and deliver people's care in a way that ensured their welfare and safety was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities).

Medicines were not safely stored as both medicine trolleys had faulty locks and the medicine fridge lock was broken. Medicines had not always been stored at the correct temperature and the medicine room temperature had not always been checked which could have made people's medicines ineffective. A controlled medicine was not stored in accordance with legislative requirements. Some prescription medicines are controlled under the Misuse of Drugs Act 1971 these medicines are called controlled drugs or medicines. There was a risk that unauthorised people could access this medicine.

The amount of medicines did not always match the stock the provider thought they had. People's medicines had not been managed safely. One person had not received an essential medicine for their health which potentially placed them at risk of ill-health. Eye drops had no date of opening and may not have been within their recommended date of usage, which placed the person at risk of receiving ineffective medicine.

Inadequate

Is the service safe?

A medicine had been bought by the provider and used for a person without seeking medical advice. This product was not suitable for the area of skin which staff had applied it to; this person was at risk of a skin reaction. A person had received covert medicine. Covert is the term used when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink. Records did not clearly document which doses had been given overtly and which had been added to food. There was no risk assessment in place to establish how this process would be facilitated safely and others protected from the risk of ingesting medicine added to food. People were at risk of harm as medicines had not been managed safely.

The provider's failure to protect people against the risks associated with the unsafe use of medicines was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities).

Staff had undergone relevant recruitment checks. Staff were only required to provide their past ten year's employment history, rather than a full employment history as required. Staff had not been required to provide a written explanation of their employment prior to this date. Staff may not have been suitable to work with people. One staff member's record did not contain photographic proof of their identity to enable the provider to verify their identity and keep people safe.

We found that the registered person had not ensured the information specified in Schedule 3, notably a full employment history, was available for all staff. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they did not use a staffing tool to assess the staffing levels required to meet people's needs. Records showed one person who was no longer accommodated had required staff supervision at night. Although the registered manager had the authority to increase staffing levels in response to people's needs, staffing levels had not been increased in response to this person's needs, which had left them at risk. Staff numbers were safe for the needs of people currently accommodated.

Cleaning of the service was completed to reduce the risk of infection to people. Some areas had an odour and this was brought to the attention of the deputy manager. Although not all staff had completed infection control training to ensure they knew how to reduce the risk of cross-infection, staff wore aprons and gloves when they provided people's care. Facilities were in place to enable people to wash their hands to protect them from the risk of cross infection. The deputy manager told us there was not a sluice for the cleaning of commode pans in accordance with best practice. They told us how commodes were cleaned and this was in accordance with the provider's infection control policy. People were safe from the risk of infection as the service was clean and staff followed the provider's infection control guidance.

Inadequate

Is the service effective?

Our findings

One person told us staff were "Kind, but not very knowledgeable." Staff files demonstrated that although staff had completed the provider's induction, not all had completed the Skills for Care Common Induction Standards (CIS), as required by the provider. The CIS are the standards people working in adult social care need to meet before they can safely work unsupervised. People were cared for by staff who had not been fully prepared for their role thereby putting people at risk of unsafe care or treatment. Records demonstrated staff had not completed all the provider's required training. Some people experienced diabetes or had a urinary catheter and required support from staff. There was no evidence to demonstrate that staff providing this care had received the relevant training. People were placed at risk of unsafe care as staff had not received all of the training they required to enable them to support people safely.

The staff supervision record from October 2014 showed seven staff had not received any supervision since this date. One staff member confirmed they had received a low level of supervision. Other staff had received one or two supervisions which were not in accordance with the provider's policy. The content of some staff supervision records was limited and did not fully demonstrate what areas had been discussed. People's care was provided by staff who had not been fully supported in their role.

We found that the registered person had not provided staff with adequate induction, training and supervision. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us the food was fine, they had enough choice, and enjoyed what they ate. One person told us "The food is good." People were at risk as their weight had not always been obtained in order to identify if they were at risk of malnutrition. People's Malnutrition Universal Screening Tool (MUST) score had not always been calculated or the results were not accurate. MUST is a screening tool to identify adults, who are at risk from either malnourishment or being overweight. The registered manager confirmed people's weights and MUST's were not being completed properly as not all staff had received relevant training or understood how to calculate the MUST score. This placed people at risk as their malnutrition score was inaccurate. Action had not been taken to make sure people at risk from weight loss were sufficiently supported. One person was on a food diary which indicated they ate little; there was a lack of evidence to demonstrate what action was taken.

The registered manager told us referrals to speech and language therapy and the dietician were made via the GP. The registered manager said they had not referred everyone they should do to the GP for referral to the dietician. The risks to people from malnutrition had not been managed effectively. Where people were on fluid charts their fluid intake was not accurately recorded to demonstrate the amount of fluids they had drunk in total across the course of the day. Staff recorded how much people drunk in terms of 'A cup of juice.' However without recording the metric volume of the cup, it was not possible to ascertain how much the person had drunk across the course of the day. To enable staff to assess if the person was at risk from dehydration. People's fluid records did not protect them effectively from the risks of dehydration.

The provider's failure to protect people from the risks associated with inappropriate or unsafe care and to ensure people's welfare and safety was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities).

The registered manager told us 25 people experienced dementia. However, Deprivation of Liberty Safeguards (DoLs) applications had only been submitted for five people. The registered manager had not considered whether the other 20 people had the capacity to agree to their care and treatment. The Deprivation of Liberty Safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. One person who experienced dementia was distressed about where they were and why, and they were not subject to a DoLs. This person's capacity had not been assessed, and consideration given, as to whether an application should be made. One person had previously left the service without staff knowing and was now on a DoLs. However, there was no written guidance for staff in relation to how this person was to be monitored to protect them from harm. People who were subject to a DoLs were not safe as there was insufficient information to inform staff about the authorised restrictions and conditions upon people.

Inadequate

Is the service effective?

Records showed on three occasions a person had been agitated and their behaviours had challenged staff, it had taken three staff to provide their personal care. There was no evidence to demonstrate this person had been protected against the risks of excessive or unlawful restraint. At the time of these incidents there was no DoLs authorisation in place for this person. Records showed only two staff had completed challenging behaviour training; staff had not received sufficient training to manage people's behaviours that challenged them. This person had not been adequately protected against the risks of the provision of their care being unlawful or excessive.

The provider's failure to ensure adequate arrangements were in place to ensure the use of any form of control was not unlawful or excessive was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities).

People's records showed some people's mental capacity had been assessed where they lacked the capacity to make a specific decision in accordance with the requirements of the Mental Capacity Act (MCA) 2005. Where a person was subject to DoLs there was a lack of evidence to show how the decision to make the application for the person had been reached. There was no mental capacity assessment or best interest decision to show they lacked the capacity to consent to their care and the application for a DoLs was in their best interests. Records showed not all staff had received training on MCA and DoLs to ensure they understood the legislative requirements, although this training had been arranged by the provider. If people lacked the capacity to consent to their care, best practice had not always been followed. The provider understood this and was taking action.

The registered manager told us GP's, the optician and chiropodist visited people at the service. People were supported to attend appointments externally as required. There was evidence people had seen nurses and social workers. People did not always experience timely access to other services such as the mental health team. One person presented with behaviours which challenged staff and were a risk to themselves and others. Records showed a referral to the local mental health team for this person was not made promptly by staff. This person did not receive effective care as a referral was not accessed quickly in response to a change in their needs. One person told us they had a dental appointment in a couple of days but they were in pain. We asked if arrangements could be made for this person to access an emergency dentist. Initially we were told no and later the registered manager agreed to make an appointment. People had access to external services but staff had not always been prompt in making referrals. This delayed people's access to healthcare when they needed it.

Requires Improvement

Is the service caring?

Our findings

One person said they felt they had "Just been dumped here," and upon admission had not had any orientation to the service, or information about mealtimes, or care, or any routines and systems. They told us they were unclear as to what treatment regime the provider had for them, as they had not been consulted. Following the inspection the provider informed us people were provided with a welcome pack upon their arrival. People's care plans contained a form which documented where people or their relatives had been involved in planning their care. People we spoke with and their relatives told us however, they had not actually felt involved in their own, or their relatives' care.

The involvement of people and their relatives in their care planning had not been fully effective. In the minutes of a relatives' meeting held at the service on 17 November 2014 we noted 'If any relatives would like to see the care plan of their relative, please just ask.' People and their relatives experience was that they had not felt fully involved in their care planning and had to ask if they wanted a copy of care plans.

The deputy manager told us people were asked by the cook in the morning what they wanted for their main meal. Pictures of the meal choices were available and staff were observed to use these to remind people about what the options were for the main meal and their choice. People were provided with information about the meal options and were asked on the day what their preference was. This assisted people who experienced dementia to make choices about their meals. Some people's bedrooms displayed a photograph of the person and a brief biography. There was no visual information besides the person's photograph such as relevant pictures or mementoes to assist people to recall this was their bedroom. People who experienced dementia would not necessarily have been able to read the biography on their door to remind them it was their room. People who experienced dementia did not consistently receive relevant information to support them.

The biographies did not uphold people's right to privacy as anyone including visitors or workmen walking down the corridor could stop and read them; people's privacy was not always promoted. One person's bedroom door remained open. They spent a large part of the day in bed. They were not adequately covered and anyone walking down the corridor could have seen them lying in their bed. A male cleaner was in the corridor cleaning during part of the time. This person's privacy and dignity had not been upheld. One staff we spoke with about upholding people's privacy and dignity told us if they provided a person with personal care they would ensure this was provided in private with the curtains closed. Staff were seen knocking on people's doors before entering and waited for permission to enter. People's care had not been consistently provided in a manner which promoted their privacy and dignity although staff understood what they should do to protect people's dignity.

People told us staff were polite, and never rude or stand-offish. One person told us "The girls are lovely; they come in and chat; take me to the lounge; give me drinks" another said "The girls are sweet and polite – I'd recommend this place." Staff were seen to be caring towards people. Staff interacted in a friendly, kindly and respectful manner with people. People were cared for by staff who were caring in their interactions with them. At lunch time staff asked people where they wanted to sit and supported them to their seats. People were asked for their preferences by staff who then responded. A person gestured that they required assistance from staff who responded promptly. People's requests for help were noticed by staff. When staff placed people's meals in front of them they told them what the meal was or asked them how they were. People's care was provided by staff who showed an interest in people. Staff reported at the information handover between shifts that a person had been up late so they had asked them if they wanted a lie-in. Staff appreciated this person may not have received sufficient sleep and gave them a choice of whether or not to get up.

Requires Improvement

Is the service responsive?

Our findings

People's care plans demonstrated they had been reviewed monthly by staff only; monthly reviews did not involve people or their relatives. The registered manager told us people's care plans were reviewed with people or their relatives last year and they were starting to review them again this year. The minutes from the relative's meeting on 17 November 2014 documented people's care plans would be reviewed. However, there no evidence to indicate this process had commenced. A person had provided feedback on their May 2014 survey that they would like a keyworker system and reviews so they could have a clearer picture of their relative's care and to share their views. The registered manager confirmed to us there was no keyworker system in place. People and their relatives had not been involved in regular reviews of their care and there was a lack of an effective process to involve them.

People had completed an 'All about me' form which provided details about their personal history, biography and preferences. They had also completed a personal preferences questionnaire which stated their preferences in relation to when they got up and went to bed and the support they required. Some people's records contained additional information from their families about their routine and preferences. People's records did not demonstrate this information had always been adequately incorporated into their care plans to ensure the delivery of their care was responsive to their needs. One person's emotional well-being care plan said they liked to have conversations with staff and people. There was no guidance for staff in relation to how to promote this based on their personal history which would provide staff with potential topics of conversation. Information provided by this person's family had not been utilised in their care plan to enable staff to meet the person's needs. The registered manager told us they had simplified people's care plans to ensure staff understood them and information about their preferences was in the 'All about me' form. People's care plans had not consistently incorporated information which the provider had gathered about people's preferences in relation to how they wanted their care provided. People therefore might not receive their care in the way they preferred.

The service had an activities co-ordinator who organised a range of activities across the course of the week, including reminiscence activities, arts and craft, walks, one to ones, music, quizzes, flower arranging, bingo and cinema. People had access to the hairdresser and a downstairs bar within which the activities co-ordinator ran some sessions. The service had a minibus they used to take people out for trips or to attend appointments. People had access to a range of activities within the service and were supported to go out as required.

The armchairs in the lounge were arranged in rows, with one row across the middle of the room, which effectively cut off those seated behind it, and offered them a view of chair backs. This configuration did not facilitate people communicating with each other or socialising. The activities co-ordinator ran a group activity in the lounge and of the 18 people present, only four were actively engaged. The layout of the lounge had not promoted their inclusion within this group. People's needs in relation to how the layout of the lounge should encourage social interaction and participation in activities. Following the inspection the provider informed us they had previously changed the layout of the lounge. However, on the day of the inspection the layout did not promote people's inclusion in the activities programme.

People told us they would be happy to do make a complaint if they wanted to, but none of them could say they had been told how; nor were they able to tell us to whom they would address it. The registered manager told us people were shown the complaints policy of which details were contained in the service user guide and the terms and conditions. People had received information about the complaints policy but they did not recall having seen it. People felt able to complain but might not have been aware of how to do so. The registered manager told us a complaint had been received in relation to meals, this had been addressed and feedback provided to staff. This person's complaint had been responded to appropriately. There was a process for people to make written complaints but people were not necessarily aware of it. People may have benefited from information about the complaints process being made more accessible.

Inadequate

Is the service well-led?

Our findings

The registered manager audited various aspects of the service during the year, including; housekeeping, maintenance, activities, medicines, controlled drugs, care plans, dining experience, nutrition and infection control. They also produced a weekly report for the provider on the quality of the service. The evidence we found did not always support the results of the audits completed. Medicines had last been audited by the deputy manager on 18 January 2015 and recorded no issues relating to medicines management. The registered manager confirmed there had been no reported medicine errors in the service within the last 12 months. The registered manager said the community pharmacy supplying medicines to the home had not carried out an audit in the last 12 to 18 months. The internal medicines audit had failed to identify any of the issues we identified with medicines and there was a lack of an effective external system to audit medicines. People were at risk from unsafe management of medicines as the medicines auditing system was not effective.

A quality audit completed on 11 February 2015 noted all people's weights and their MUST assessments had been completed. It noted all staff supervisions were up to date, and all staff had completed safeguarding, MCA and DoLs training. People were at risk of malnutrition as their weights and MUST assessments had not all been completed and staff had not completed the required training and supervisions.

There was no process for recording incidents and cross referencing them with people's daily care records to ensure post incident monitoring and required follow up action was taken by staff. People were at risk from further harm as incident forms had not always been completed although their records indicated incidents had occurred. The registered manager told us they had not historically reviewed incident forms and had only just started to do this within the past fortnight. The registered manager had failed to investigate the circumstances that resulted in a person's care having to be provided by three staff on occasions. There had not been an analysis of these incidents, to determine if changes needed to be made to the treatment or care provided for this person. People had been left at risk of potential harm as the registered manager had not reviewed incidents to assess if action was required to keep them safe following incidents.

There were processes in place to seek people's feedback on the quality of the service through surveys and meetings. However, the registered manager had not given due consideration to the feedback received from people's relatives and staff about people's care. One relative had completed a customer care form in April 2014 and commented about their relative 'Being hit over the head by another resident.' There was no evidence this feedback had been investigated and the registered manager had no recollection of this issue being raised. The failure to follow up on this feedback left this person at risk of harm. Staff told us they had reported to management that medicines needed to be returned to the pharmacy and this had not been actioned. A staff member's supervision notes showed when they had raised the issue of requiring four staff at night, no action had been taken by the registered manager. People were at risk of harm as feedback had not always been listened to.

The provider's failure to effectively operate the systems to monitor the quality of the service provided, identify risks to people, to have regard to feedback and to analyse incidents was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities).

People's records did not always contain appropriate information. One person had a behaviour monitoring chart in place. However this was not actually a chart of the person's behaviours in terms of antecedents, behaviour and consequences to enable staff to understand the reasons for the person's behaviour, it was only a record of what happened. This person was at risk of not having their needs met as the records related to their behaviours did not enable staff to understand them and take appropriate action in response. People's records were often incomplete. Incident forms had not always been completed, MUST charts were incomplete. Medicine administration records were inaccurate, care plans were not always in place and people's care plans did not always contain sufficient information. Audits completed by the registered manager did not accurately reflect the quality of the service. People were at risk of harm due to poor record keeping.

It was difficult to follow through information in some people's records as older records were stored or archived

Inadequate

Is the service well-led?

separately and not easy to locate, if staff needed to access this information. People were at risk of receiving inappropriate care as their records could not all be found promptly.

We found that the registered person had not maintained accurate records in relation to peoples' care which could not always be located as required. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One staff member told us the registered manager was "Very approachable." The registered manager told us they were approachable and spent time on the floor. People and staff liked the registered manager. However, the findings from the inspection demonstrated they had not carried out their roles and responsibilities fully to ensure people received a safe, effective, caring, and responsive service from staff who were well led. People's care had not been provided in a service which was well-led. When the results of the inspection were reported back to the Group Operations Manager and the provider they took swift action. They produced an emergency action plan in response to the issues raised, to ensure people's safety and to address the issues identified.

The registered manager told us the provider's values were covered with staff during their induction and as part of their supervision. However, there was no written evidence to demonstrate how this had taken place. The service user guide outlined the values of the service as providing people with privacy, dignity, independence, choice, rights and fulfilment. However, we did not find people's rights, privacy and dignity had been always been upheld by all staff. Safety was not one of the core values and people had not always been kept safe within the service. The culture of the service did not appear open, transparent or pro-active. Records showed there had been under-reporting of incidents outside of the organisation. People's care was provided in a culture that did not reflect on incidents or staff practice to ensure people's care was provided safely and in accordance with best practice.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person had not ensured the information specified in Schedule 3, notably a full employment history, was available for all staff. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 19(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered person had not provided staff with adequate induction, training and supervision. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had no maintained accurate records in relation to peoples' care which could not always be located as required. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person had not made suitable arrangements to ensure people were safeguarded against the risks of abuse by taking reasonable steps to identify the possibility of abuse and by responding appropriately to any allegation of abuse. There were not suitable arrangements to protect people from the risk of control or restraint being unlawful or otherwise excessive. Regulation 11(1) (a) (b) (2) (a) (b) Health and Social Care Act 2008 (Regulated Activities).

The enforcement action we took:
The provider was served with a warning notice in relation to regulation 11 which required them to become compliant with this regulation by 4 May 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not protected people against care that was inappropriate or unsafe. They had not planned and delivered care in a way as to meet people's individual needs and ensure their safety and welfare. Regulation 9 (1) (b) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities)

The enforcement action we took:
The provider was served with a warning notice in relation to regulation 9 which required them to become compliant with this regulation by 4 May 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person had not protected people against the risks of inappropriate or unsafe care. They had not operated effective systems to identify, assess and

This section is primarily information for the provider

Enforcement actions

manage risks to people. They had not had due regard to people's comments. They had not analysed incidents that had the potential to cause harm to people. Regulation 10 (1) (b) (2) (b) (i) (c) (i) Health and Social Care Act 2008 (Regulated Activities).

The enforcement action we took:
The provider was served with a warning notice in relation to regulation 10 which required them to become compliant with this regulation by 4 May 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person had not protected people against the risks associated with the unsafe use and management of medicines. Regulation 13 Health and Social Care Act 2008 (Regulated Activities).

The enforcement action we took:
The provider was served with a warning notice in relation to regulation 13 which required them to become compliant with this regulation by 4 May 2015.