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Eboracum House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 10 August 2016 and was unannounced which meant that people did not know we would be carrying out an inspection on this day. We last inspected the service in May 2015 and found the service was not meeting the requirements of the regulations we inspected at that time. This was in relation to the safe management of medicines and the need to gain consent.

Eboracum House provides accommodation for up to 18 older people who have personal care needs and some of who are living with dementia. There were 16 people living at the home at the time of our inspection.

There was no registered manager at the home. However there was a manager who was in the process of registering with the Care Quality Commission. 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.

We found the management of medicines was not safe. We found multiple and serious concerns about the storage of medicines and concerns about the records which were kept to show what medicines had been administered to people who lived at the home.

Recruitment processes were reviewed and we found the provider was carrying out appropriate checks which allowed them to make safer recruitment decisions.

The home appeared to be generally clean; however there were areas where malodours were present. There was work in progress to eliminate these odours and the hours for domestic staff had been increased to include weekends to improve the general cleanliness in the home.

We found concerns in relation to the safety of the building with regard to an electrical installations report which had been carried out in June 2015. There were areas of serious concern identified which had not been actioned. The operations manager took immediate action on the day of inspection to ensure this work was carried out.

We saw staff had undertaken a range of training to ensure they had the required skills and knowledge to carry out their roles. Staff received supervision and appraisals and told us they felt supported by the management team.

We found consent to care was not always clearly sought or gained, as care plans were not signed by people to show their agreement to the support they received. We saw no evidence that people or their relatives were involved in their care planning.

The provider had made applications for Deprivation of Liberty Safeguards to be authorised for people who had been assessed as not having the mental capacity to make decisions about where they lived. We were however concerned other people were being deprived of their liberty which had not been recognised as there was a door from the main area of the service to the entrance which some people would not be able to open as there was confusion handles fitted and the top handle was very high up.

People and their relatives spoke very positively about the quality of the food which was served and the variety of meals, drinks and snacks which were available to people throughout the day.

There had been little thought given to the suitability of the environment for people living with dementia, as the bedrooms were not easily distinguishable from each other and corridors were hung with mirrors which people may find confusing and disorientating.

Staff were kind, caring and compassionate when supporting people. We heard friendly chatter throughout the day and staff made every effort to include people in conversations. Staff respected the privacy and dignity of the people who lived at the home and maintained their confidences.

Care plans had recently been re-written and there was some evidence that they were more person-centred, however there were sections which were still missing, these included 'about me' and end of life care planning.

Most people felt that activities had improved, although some people told us there was still little going on. There was a recently appointed activities coordinator in post.
Staff morale was good. People, their relatives and staff all told us the manager and the operations manager were visible in the home and were approachable and supportive.

Processes which were in place to monitor the quality and safety of the service were not effective as they had not recognised all the concerns we found during inspection, and in cases where concerns had been identified action had not been taken to resolve the concern effectively and in a timely manner.

We found records were not always filled out correctly and were not filled out consistently. This was the case with Medication Administration Records (MARs), repositioning charts and food and fluid records.

The provider was notifying the Care Quality Commission appropriately of notifiable events and incidents.

The provider was not meeting the requirements of four regulations of the Health and Social Care Act 2008. You can see what action we told the provider to take at the back of the full version of the report.

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 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.

We found that medicines were not managed safely, which put people at risk of harm. We had concerns regarding the safety of the building and the provider had not taken timely action to address these serious concerns

There was sufficient staff on duty to meet people's needs. Staff were able to demonstrate their understanding of how to safeguard vulnerable people. There was a recruitment process in place which allowed the service to safely recruit staff.

There were individual risk assessments in place in order to manage the risks to people in the home.

Is the service effective?

Requires Improvement

The service was not always effective

Staff undertook regular training which gave them the skills and knowledge they needed to undertake their roles. Staff received regular supervision from more senior staff in the home.

People spoke very positively about the quality and choice of food they enjoyed and we saw there was access to a choice of drinks throughout the day.

The provider had not taken appropriate action to ensure they were seeking and gaining consent to care from people who used the service in line with the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and compassionate towards people who lived at the service. Staff maintained people's privacy and dignity.

We saw staff interacted positively and frequently with people and were interested in their well-being. People were encouraged to

be as independent as possible.

There was no end of life care planning in place, however this had been identified and was about to commence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans had been re-written and there was evidence of personal details being included in these documents, however there were still a number where personal information was yet to be included including personal histories and food preferences.

People told us there were more activities taking place and they enjoyed these, although some people still felt there were more activities needed to meet their needs.

Complaints were recorded and we could see these had been investigated and resolved.

Is the service well-led?

Inadequate

The service was not always well-led.

Whilst there were auditing processes in place, these were not effective in identifying concerns and ensuring these were resolved in a timely manner.

Staff morale was good, and staff reported the management team was approachable and supportive.

Records were not always completed in a timely manner and there were omissions in key records for example repositioning and medicine records.

Eboracum House

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.

The inspection took place on 10 August 2016 and was unannounced. This meant the provider and staff were not aware we would be carrying out the inspection on that day. The inspection team consisted of two adult social care inspectors.

Prior to our inspection we reviewed the records we held about the location including notifications which had been sent to us by the provider.

As part of our inspection we carried out observations of the care and support which was taking place. We spoke with five people who used the service and three visiting relatives to gain their opinions on the home; we spoke with staff of all levels including the operations manager, the home manager and care staff. We also spoke with the cook.

We looked at a variety of records which were kept in relation to the care and support which was given to people and the processes which were in place to monitor the quality and safety of the service. These records included the care records for four people, staff recruitment files for three staff, safety and maintenance records, daily care records and quality and safety checks which had been carried out since our last inspection.

Inadequate

Is the service safe?

Our findings

We found at our last inspection the provider was in breach of Regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach was in relation to the safe storage of medicines, and the records which were kept in relation to medicines which had been given to people.

We looked at how the home managed medicines, and whether the provider had made the required improvements.

We found the treatment room was situated in the basement of the building, which was down some stairs from the main area of the home. This meant that the medicine trolley could not be stored in this room as had been the case at the last inspection. The home had changed the storage of the medicine trolley to be kept outside the manager's office, where it could be locked securely by means of a chain and lock. However on the day of our inspection we found the medicine trolley was kept in the dining room, and was not secured to the wall as a result. We asked the operations manager about this and they told us it was the result of a piece of furniture being moved which meant the trolley could not be stored in its usual place. The operations manager assured us they would take immediate action to ensure the medication trolley was appropriately secured when not in use.

We looked at the medication administration records (MARs) which were in place. We found these were printed sheets supplied with the medication which was supplied in the main in pharmacy filled monitored dosage systems (MDS). We found that whilst the majority of the records relating to medicines which were administered from MDS were present, there were issues with the codes which were being used by staff. The MARs have a key printed on each sheet which details the codes to be used for different events, for example a person who refuses their medicine would be recorded as 'R', if a person was in hospital this would be recorded as 'H'. There were codes in use which were not listed and had been 'made up' by staff at the home. For example we saw the use of 'G' and 'O'. G was used to record when people did not have their as and when needed (PRN) medicines. We asked the manager about the use of these codes. They told us they 'had noticed' them being used. We asked them whether they felt this was acceptable and they told us it was not, however there was no evidence any action had been taken to stop this practice.

We found where people had PRN medicines prescribed there were several concerns about how this was managed. Staff did not record what dosage of a medicine they had given where there was an option for one or two tablets, which meant there was no record of what dose the person received, it also meant the medicine stocks could not be monitored as there was no record of how many had been dispensed. The other concern was that there were a very large number of PRN medicines being recorded as not required (G), refused (R) or withheld (W), in all three cases staff need to record the reason on the reverse of the MAR. We found staff were not recording the reason, with a very small number of exceptions, for example we saw a MAR where there had been 24 doses recorded as refused, yet there was only one entry giving a reason for the refusal, and another example where there were 42 doses recorded as refused with only 4 entries giving a reason. We spoke with the manager about this who told us they were aware of the issue, and told us they

had spoken to all staff who administered medication about the importance of keeping accurate records.

We looked at the storage of medicines in the medication fridge. We found there were no records available to show the temperature inside the fridge was monitored each day to ensure it was within the recommended limits. We found the fridge was very cold and there was a small freezer compartment which was covered in a thick layer of ice on the outside.

We found there were two bottles of eye drops stored in the fridge, one of which had no dispensing label to show to who it was prescribed or when it was dispensed, this was open and had been used as there was little left, there was no record of when the bottle was open. There was another bottle of eye drops which showed it had been dispensed in April 2016, this was again open and had been used. There was again no date recorded when the bottle had been open. Both bottles clearly stated they must be discarded 4 weeks from the date of opening.

We found there were ampoules of injectable medicines in the fridge, the expiry date of these had past which meant they were not fit to be used. We also found a plastic tub, which contained 6 injection pens and a needle attachment for the pen. All the pens were floating in water which had debris floating in it, we found only one person was prescribed this medication which meant there was no reason for there to be more than one in use. We alerted the operations manager to this immediately as this posed a significant risk of harm to the person who required the medicine. The operations manager was not aware of the situation and could not offer any explanation as to how this would have happened. The operations manager took immediate action to remove the medicines and ensure there was a new safe supply in place.

We reviewed the management of controlled drugs in the home. Controlled drugs are medicines which require extra security measures to be taken and very specific records to be kept of their use due to the potential for misuse of these drugs. We found the controlled drugs record book was not correctly filled out. There were records of a controlled drug belonging to a person which was not detailed in the index for the records. On checking the drugs which were stored in the controlled drugs cupboard, we found there were subcutaneous patches prescribed to one person, The records kept and the number which was in stock did not match as there were less in stock than records indicated there should have been. There was also an issue as the last dose had only been signed for by one member of staff and controlled drugs need to be countersigned by another member of staff. We again immediately alerted the operations manager to the missing drug. The operations manager carried out a search and found the missing drug on the floor under a box of supplies.

We found there was a bag which contained a significant amount of controlled drugs which were prescribed to a person who had died several months before. These drugs should have been returned to the pharmacist at the earliest opportunity following the person's death.

We found there were multiple items stored in the controlled drugs cupboard which should not have been stored there, these included medicines which do not require being stored in this way and items which were not related to medicines.

These examples demonstrate a continued breach of Regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people were put at risk of harm due to the unsafe management of medicines.

We looked at the organisation's recruitment process. We reviewed the records of three members of staff who had worked at the home for varying lengths of time. We found there had been appropriate checks carried

out including disclosure and barring service checks (DBS) and references had been gained from previous employment, these checks help employers make safer recruitment choices.

People and their relatives told us they felt they were safe. Staff had undertaken training in protecting vulnerable adults from harm or abuse. Staff were able to demonstrate their knowledge of the types of abuse which could occur and they were confident that any concerns which were reported would be dealt with appropriately. The manager of the home also understood their role and responsibility in reporting any concerns to the local authority safeguarding team.

We found that whilst the home appeared to be clean, there were malodours present in some areas around the building. People and their relatives we spoke with told us, "I sometimes feel the cleaning could be better, [relative] moved rooms and the new one hadn't been cleaned properly," and "The downside is the building, they re-decorate it frequently, but it still has odours." We discussed the malodours with the manager, who told us they were in the middle of replacing flooring in the home as this had been identified as the source of the odours. The manager also told us they had employed a second cleaner to make sure there was a cleaner on duty at the weekends and they worked longer hours through the week as well.

We reviewed the risk assessments which were in place in relation to the care and support people needed. We saw there were risk specific assessments which identified the risk to the person and the measures which needed to be taken to minimise the identified risk.

We looked at the safety checks which had been carried out for the building. We found there had been checks carried out on the electrical installation of the building in June 2015. The report showed there were areas of significant concerns identified. There were different ratings awarded depending on the urgency of the repair required and the risk to people. C1 was the highest level of risk which required 'immediate remedial action required – danger present, risk of injury'. There was also a C2 which required 'urgent remedial action – potentially dangerous'. We asked for evidence this work had been carried out. The operations manager was unable to provide evidence of this. The company who had carried out the checks were contacted and attended the home immediately. The operations manager confirmed that whilst there had been a mistake made by the electrician on one of the actions, the other actions were valid and would be carried out as soon as possible.

This was a breach of Regulation 15 premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had not taken timely action to ensure repairs were carried out where they were needed to ensure the safety of the premises.

We found there was sufficient staff on duty to meet people's needs. We observed that staff were able to spend time with people and assisted them without rushing. Call bells we heard were answered without delay.

Requires Improvement

Is the service effective?

Our findings

A person who lived at the home told us, "Staff seem to know what they are doing here."

We found staff had undertaken a range of training, which included mandatory subjects, for example moving and handling, first aid and safeguarding vulnerable adults. Staff also had access to a range of other subjects including dementia awareness, skin viability and end of life advance care planning. Staff told us they had undertaken an induction prior to starting work at Eboracum House, and told us they felt they had the skills and knowledge they needed to carry out their roles effectively.

Staff told us and records confirmed that they received regular supervision with a senior member of staff. Supervision is important as this is an opportunity for staff to discuss any concerns they have, ask questions and gain feedback on their practice and performance in a one to one meeting. Staff told us they were also in the process of receiving their annual appraisals, which are meetings which review the performance of staff and look at areas for development and improvement.

Staff told us they felt the manager and the operations manager were both very approachable and offered a good level of support in a manner which put staff at their ease and built confidence.

At our last inspection we found the provider was in breach of Regulation11 need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as they were not obtaining consent for decisions following the principles of the Mental Capacity Act 2005 where people lacked capacity. We reviewed the provider's processes and practice to see if the required improvement had been made.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and specifically on the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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 reviewed the processes which were in place to assess the mental capacity of people and to ensure that consent to care was gained within the principles of the MCA. We found there was evidence of capacity assessments being carried out; these were in the main in relation to day to day living. There was no clear

outcome of these assessments as there was no judgement made. We saw there were records which showed applications had been made to the local authority where it had been deemed that people lacked capacity to make their own decisions about where they lived for a Deprivation of Liberty Safeguard to be granted. We were however concerned that other people were being deprived of their liberty and this had not been recognised as there was a door from the main area of the home to the reception area where the front door was situated. This door had confusion handles fitted, the top one of which would not have been in reach for some of the people who lived at the home. There was no recognition of this being a deprivation of people's liberty and there was no mention of the restraint or risk assessments in place in any of the care files we reviewed.

It was not clear from the care files whether consent to personal care had been gained as the consent form which was in place asked for consent for specific tasks such as photographs being taken and trips out. This was discussed with both managers who assured us they would ensure consent was clearly gained and where people were unable to make their own decisions either a person who was a Lasting Power of Attorney would make decisions on their behalf and this paperwork would be available in the care file, or there would be a best interest decision made.

This demonstrated a continued breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the required improvements had not been made.

People and their relatives all spoke very highly of the food which was on offer. People told us "the food is really nice here" and "They offer us lots of choices, and they try to accommodate our preferences."

On the day of the inspection we saw people were being offered a choice of breakfast and this was served individually as people came into the communal areas. Lunch was served as 12:30 and there were signs up around the home asking visitors to avoid meal times as they were 'protected'. There was a choice of roast chicken dinner or homemade soup available for lunch. We observed people being given a choice of where they ate, as there were small tables in various rooms where people sat together for meals. Staff were very patient and chatted to people throughout lunch; both managers came to assist people with their meals and to chat to people. We saw there was a range of drinks offered with meals and there were drinks and snacks offered to people throughout the day.

We saw from people's care records that they had good access to a range of healthcare professionals and people told us staff were very quick to call out a Doctor if they were feeling unwell. One person told us, "They [staff] are very quick off the mark calling the doctors if we need them."

We looked around the home and found that whilst there had been some efforts made since our last inspection to improve the design of some aspects of the service, the environment remained unhelpful to people who were living with dementia. For instance on the ground floor corridors there were mirrors at junctions of corridors, which may be confusing to people with a cognitive impairment. The door signs on one corridor were all identical and whilst there had been frames put up for memory boxes outside the rooms on the ground floor very few of these had been filled to help people identify their rooms.

We also noted on the upper floors the bedroom numbers had been changed, the only marking to show the newly designated room number was a small handwritten square of paper which was taped to the door. Most of these had curled up and were not legible unless flattened out. This showed the provider had not considered the needs of or taken measures to ensure the environment was suitable for the people who lived at the home, despite them telling us they would at the last inspection.

Good

Is the service caring?

Our findings

People who used the service told us, "I'm generally very happy, they [staff] are all very nice." A relative told us, "The staff are very, very nice they are very accommodating with [relative].

We observed staff interacting with people and their relatives throughout the inspection. We found staff were kind, caring and compassionate when speaking to people. There was a pleasant friendly atmosphere and staff made every effort to include people in conversations which were taking place. We heard staff chatting with people and their relatives about a wide range of topics and there was 'friendly banter' and laughter regularly heard.

Staff were knowledgeable and knew people well; staff used this information to judge when to interact with people and when it would be preferable to give people some space. We saw there was a low level of agitation present with some people who were living with dementia and staff were understanding of this and use distraction techniques to avoid any escalation of potential incidents, this was particularly important given the small size of the building and the number of confined spaces (corridors).

We looked at the care plans which were in place for people. We could not see any evidence of people having been involved in their own care planning and review. Staff did involve people in the day to day goings on of the home for example encouraging people to help them with small tasks like laying tables for meals, but this was limited.

We saw and heard staff asking about people's well-being throughout the day. Staff made sure they kept coming back to check on people who were not in the main areas, offering them drinks and discreetly asking if they needed any assistance for example to use the toilet.

Staff were mindful of maintaining people's privacy and dignity and we did not hear any conversations which would have compromised a person's privacy. We saw staff were careful to ensure people remained covered when they were being assisted to move, and were discreet when supporting people with personal care needs.

We saw and heard staff encouraging people to be as independent as they were able, and staff were patient when assisting people to give them the opportunity to complete tasks independently.

We looked at what provision there was in the home for people as they approached and reached the end of their lives. We saw there were no end of life care plans in place in the care files we reviewed, however this had been identified by the manager and they had asked key staff to complete these documents. We also noted in the care files we reviewed there was no reference to people's cultural or spiritual needs, such as access to a church service, or any particular cuisines they may require for cultural reasons. Spiritual needs may also be particularly important to people at the end of their lives.

Requires Improvement

Is the service responsive?

Our findings

People who lived at the home told us, "I would join in with activities, but they never do any." A relative told us, "The activities are a work in progress. There is room for improvement. Staff are very nice but there are limited opportunities for social activities."

People we spoke with had mixed feelings about the activities which were provided in the home. Some people felt there had been an improvement in the amount and variety of activities on offer, whilst other people told us there weren't any they could get involved in. We saw there was a programme of activities on a board in the reception area of the home; however this was not accessible to everyone as it was displayed in the reception area which not everyone could access due to the confusion handles on the access door. The programme was handwritten on a whiteboard; the writing was neat but was small and would be difficult to read if a person had poor eye sight. The activity programme was for four weeks; however we noted there were no dates on the weeks, so it was impossible to know which the current week was.

We saw on the day of inspection there was an entertainer who came in the afternoon to sing with people who wished to participate; a group of people joined in with this activity and clearly enjoyed it. We spoke with the activities coordinator, who was relatively new to the home. They told us they played giant board games, held reminiscence groups, and arrange people of interest to come to the home, they told us they had arranged for a retired cricketer to come and speak to people and show them sporting memorabilia. The activities coordinator told us they tried to arrange activities which would interest people but this was dependent on the individual whether they chose to join in.

We saw and heard people who used the service being offered choice in every aspect of their daily lives. This included where they wanted to sit, what they ate and drank, people told us they chose their own clothes each day and whether they joined in with what was taking place. People were able to go get up at the time of their choosing and went to bed when they were ready. One relative told us "It never feels likes an institution, it feels like their home."

We reviewed the care records for four people who lived at the home. We found that whilst there had been work carried out to improve care plans since our last inspection there was still further improvement needed to ensure care plans were complete and met all the person's needs.

The manager told us they had reviewed all the care plans and had identified shortfalls in the level of detail and felt the care plans were not person centred. The manager had re-written everybody's care plans as a result of this. However we found there had been a very recent review carried out of care files by the manager, and this had identified there was still sections of the care records which were not completed. The main areas in the care files we looked at were food preferences, end of life care plans and the 'about me' section. There was an action plan in each of the files we reviewed which detailed what was missing and supplied the templates which would be needed by staff to complete those sections. We asked the manager why these sections had not been completed when the care plans were re-written, the manager told us they had sent 'about me' documents to people's families to fill out and were waiting for these to be returned, and they

said they had assigned staff to complete the other sections that week.

We did not see any evidence in the files we reviewed of people or their relatives being involved in the planning or creation of care plans.

Care plans stated they would be reviewed monthly, however because all the care plans were newly written within the past month, there were no review records so we were unable to see whether reviews were thorough and included relevant information from recent events for example visits from healthcare professionals.

We reviewed the complaints file which was kept in the home. We found there were records of complaints which had been received and these had been investigated and responded to appropriately and in a timely manner. People and their relatives knew how to complain and told us they would speak to the manager or the operations manager. We did speak to one relative who told us they had made a complaint, although they were unsure of the date. We could not see this complaint in the complaints file. We asked the manager who told us this must have happened before they came into post, they told us they knew this as the complaint was around a hospital admission and the person had not been in hospital since they had been at the home.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in post at the time of the inspection; however there was a manager who was responsible for the day to day running of the service. The manager told us they were in the process of registering with the Care Quality Commission. There was also an operations manager in post to support the manager.

People and their relatives told us both the manager and the operations manager were approachable and were always around in the home to speak to. We saw that this was the case on the day of the inspection.

Staff we spoke with told us, "The managers are brilliant; I enjoy getting up and coming to work." And, "When I first came they [managers] didn't want to seem bossy, but they gave me advice on what to do around people's routines and what people liked. It was nice and really helpful."

Staff morale was good in the home and staff told us they enjoyed working at the home, and were passionate about caring for the people who lived there. Staff told us they would recommend the home to anyone they knew who needed residential care and support.

We looked at the processes which were in place to monitor the quality and safety of the service. We found that whilst there were regular checks being carried out, and some of the concerns we found had been identified, there had not been action taken to ensure there had been improvement and the concern had been resolved.

We found in the medicines audits that missing signatures on medicine records and staff not recording reasons when medicines were not given had been identified on every audit. We saw that the manager had spoken to staff about the importance of accurate record keeping, however this had not rectified the situation and these concerns were still present in current medicine records. We spoke with the manager and the operations manager about this and they assured us they would take further action to ensure the process was followed correctly by staff to reduce the risks to people who lived at the home from poor medicines management. We also found records which showed some of the other concerns we had found around medicines had been identified, these had not been actioned.

We found there had been audits carried out of care records in April 2016, which showed the missing sections of the care files had been identified, however these had still not been completed on the day of inspection.

There were lots of other checks being carried out in the home, which included accident and incident monitoring, daily walkarounds, handover audits and daily checks. We found the accident and incident audit did not analyse the information which had been collected, for example to show the time of day falls had happened or the area in the home, this would allow the provider to see if there were any areas of the home which were hazardous or if there was a time of day when perhaps more staff were needed.

We saw in the daily checks that areas were just recorded as 'Yes' or 'No', these included MAR, medicines

fridge, medicines trolley away, and whilst these had been recorded as 'Yes' we found concerns with these areas within the home during the inspection. The multiple and serious concerns we found in relation to the management of medicines clearly showed the processes to ensure the safety of the use of medicines in the home were not effective and there had been no oversight of these from the registered provider.

We asked the manager and the operations manager about senior manager visits to show they were monitoring the quality and safety of the service and that the registered provider had oversight of the home. The operations manager said they did regular checks, however they did not supply any evidence of these to show what checks had been carried out or what action they had taken as a result.

We found from records of meetings and supervisions that staff had not adequately filled out various records, these included positioning charts for people who were at high risk of pressure area damage, food and fluid charts and MARs. We spoke with the manager about this and they told us they had spoken with staff and kept on reminding them of the importance of accurate record keeping, however told us this was still an issue within the home. The manager had not taken any further action.

These examples demonstrate a breach of Regulation 17 good governance of the Health and Social Care Act (Regulated Activities) Regulations 2014 as systems which were in place to monitor the quality and safety of the service were not effective and there was no evidence that the provider had oversight of these systems.

We reviewed the process which was in place to gain feedback from people who lived at the home and their relatives. We found there had been questionnaires completed around the time the manager had commenced their post (April 2016). We saw there had been six completed questionnaires and the results of these had been analysed and actions had been put in place to improve the areas which had been highlighted. The manager wrote a letter in response to the questionnaires explaining what had been done as a result of people's feedback.

We found the provider was meeting the requirements of their registration with CQC as they were appropriately notifying us of incidents as specified in the guidance relating to notifiable events.